
The Economic Costs of Substance Abuse

**Economic
Costs**

United States

Washington

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The Economic Costs of Substance Abuse in the United States

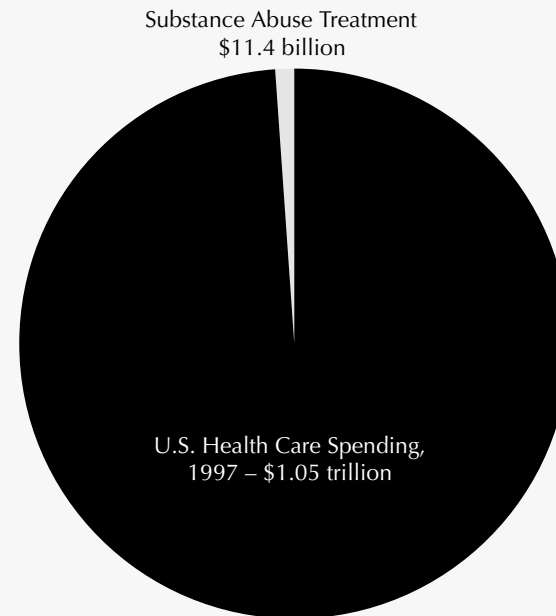
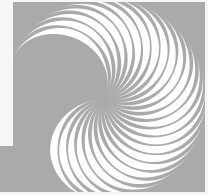
Two studies – one sponsored by the National Institute on Alcohol Abuse and Alcoholism, the other by the White House Office of Drug Control Policy – estimate the total economic costs of alcohol and drug abuse in the United States at \$328 billion in 1998.¹

Among the study's key findings were:

- Alcohol abuse accounted for 56.3% of the total economic costs; 43.7% were attributable to drug abuse.
- More than 55,000 deaths were attributable to substance abuse, 65% of them to alcohol.
- Total medical costs related to alcohol and drug abuse (\$31.8 billion) were approximately two-and-a-half times that spent on treatment (\$12.9 billion).
- Of the \$143.4 billion in economic costs related to drug abuse, 69% were in lost productivity, 9% in health care costs, and 22% in other costs, including the costs of crime, police, and the criminal justice system.
- Health costs related to alcohol abuse (\$18.9 billion) were 68% higher than for drug-related health costs (\$12.9 billion).
- Only 3.9% of total economic costs were for alcohol/drug treatment.

¹ Harwood, H., *Updating Estimates of the Economic Costs of Alcohol Abuse in the United States: Estimates, Update, and Data*. Rockville, MD: U.S. Department of Health and Human Services, U.S. Public Health Service, National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism, 2000; Office of National Drug Control Policy. *The Economic Costs of Drug Abuse in the United States, 1992-1998*. Washington, DC: Executive Office of the President, 2001.

Nationally, Only 1% of the More than Trillion Dollars Spent on Health Care in United States Goes for Substance Abuse Treatment.



Source: Coffey, R. et al., *National Expenditures for Mental Health and Substance Abuse Treatment, 1997*. Substance Abuse and Mental Health Administration, Center for Substance Abuse Treatment and Center for Mental Health Services, 2000.

A 2000 study published by the federal Substance Abuse and Mental Health Services Administration found that, of the more than \$1.05 trillion spent on health care in the United States in 1997, only approximately 1% (\$11.4 billion) went for substance abuse treatment.¹

Despite scientifically proven cost offsets in decreased mortality, lower crime and criminal justice costs, high worker productivity, less reliance on public assistance and other social services, fewer medical and psychiatric hospitalizations and emergency room visits, and lower health care costs, chemical dependency treatment remains extremely underfunded at both the state and federal level.

¹ Coffey, R. et al., *National Expenditures for Mental Health and Substance Abuse Treatment, 1997*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, Center for Substance Abuse Treatment and Center for Mental Health Services, 2000.

The Economic Costs of Substance Abuse

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The Economic Costs of Substance Abuse in the Washington State

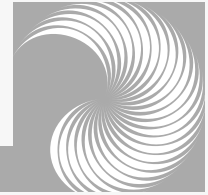
A study sponsored by the Division of Alcohol and Substance Abuse estimated the total economic costs of alcohol and drug abuse in Washington State at \$2.54 billion in 1996.¹ This represents approximately \$531 for every non-institutionalized resident in the state.

Among the study's key findings were:

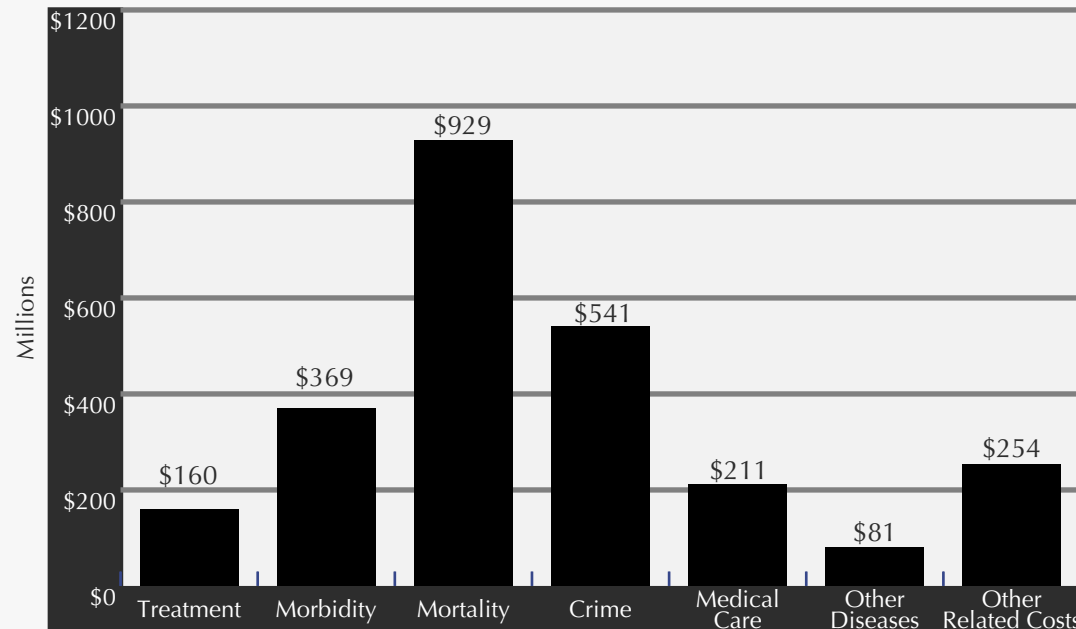
- *59% of the economic costs were attributable to the use of alcohol; 41% to the use of drugs.*
- *There were 2,824 deaths in 1996 caused by or related to alcohol or drug abuse, representing approximately 70,000 potential life-years lost.*
- *Of the 2,824 deaths, 2,318 were alcohol-related, and 506 were drug-related.*
- *Leading causes of substance abuse-related deaths were motor vehicle accidents (353 deaths), alcohol cirrhosis (291 deaths), and suicide (223 deaths).*
- *Of 217 arrests for homicide, 65 were alcohol-related, and 22 were drug-related.*
- *Of 6,003 arrests for felonious assault, 1,801 were alcohol-related, and 144 were drug-related.*
- *There were 16,000 hospital discharges classified as alcohol- or drug-related.*
- *Total estimated alcohol- and drug-related crime costs in 1996 rose to \$541 million from \$348 million in 1990, representing a 55% increase.*

¹ Wickizer, T., *The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999.

Costs Related to Mortality, Crime, and Morbidity Represent the Largest Economic Costs of Drug and Alcohol Abuse.



Economic Costs of Drug and Alcohol Abuse in Washington, 1996



Source: Wickizer, T., *The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996*. Washington State Division of Alcohol and Substance Abuse, 1999.

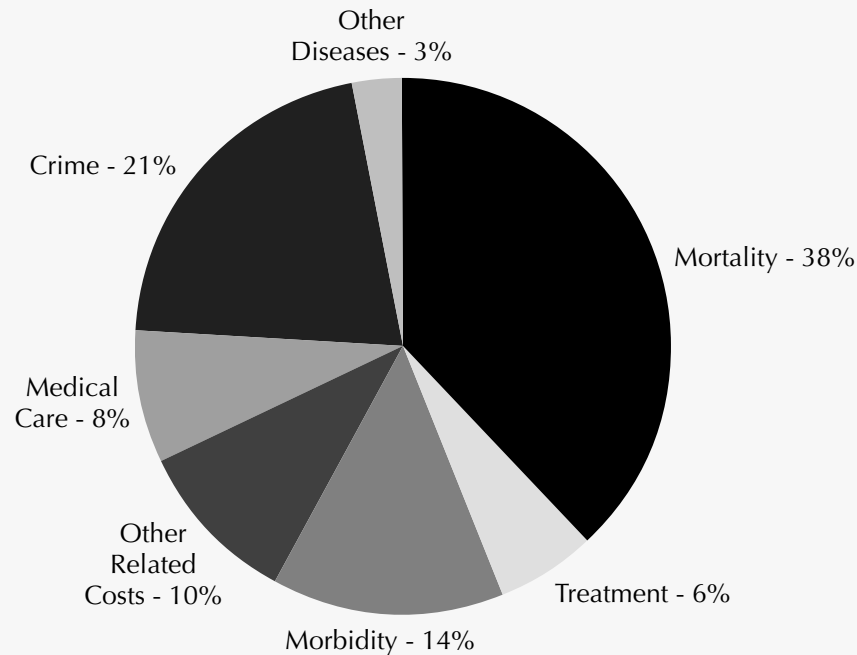
This graph indicates that mortality-, crime-, and morbidity-related costs represented the largest economic costs of substance abuse in 1996. The estimated cost per death measured in terms of lost income was \$329,000.¹ Adult and juvenile arrests for drug offenses in Washington State increased 287% from State Fiscal Years 1985 to 2002, while adult felony superior court filings for drug offenses increased by 406% in the same period.

¹ Wickizer, T., *The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999.



Treatment Represented Only 6% of the Total Economic Costs of Alcohol and Drug Abuse in 1996.

Distribution of Drug and Alcohol Costs

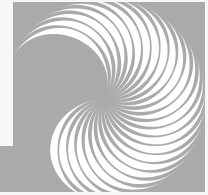


Source: Wickizer, T., *The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996*. Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999.

This chart indicates that alcohol and drug treatment represents a very small fraction of the total economic costs of substance abuse in Washington State.¹ Yet, data — much of which is contained in this report — indicate that treatment can contribute significantly to lower morbidity and mortality, decreased crime, increased employment and higher worker productivity, reduced spread of infections diseases, and lower medical costs. Alcohol and drug treatment continue to be wise investments in the health and safety of communities, and the economic vitality of Washington State.

¹ Wickizer, T. *The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999.

Impacts of Substance Abuse on the Washington State Budget



A 2001 study conducted by the National Center on Addiction and Substance Abuse at Columbia University (CASA) estimated 1998 state government spending on the consequences of substance abuse in Washington State at \$1.5 billion. Only 4% of that total was spent on prevention and treatment.¹

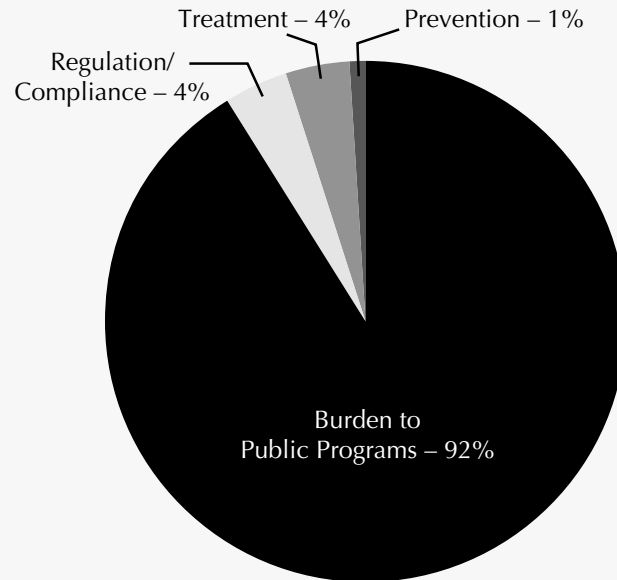
Other key findings of the study included:

- *Nationally, of a total of \$620 billion in state government spending, \$81.3 billion (13.1%) was used to deal with substance abuse and addiction.*
- *Of every such dollar spent by states, 96 cents went to “shoveling up the wreckage of substance abuse and addiction”; only four cents was used to prevent and treat it.*
- *Combined, states spent 113 times as much to deal with the devastation substance abuse and addiction wrought upon children as they did to prevent and treat it.*
- *Of the \$25 billion spent on dealing with the impacts of substance abuse on children, \$16.5 billion was borne by the public education system; another \$5.3 billion was spent on services for children who were victims of substance abuse and neglect; and almost \$3 billion was spent serving substance-involved youth in states’ juvenile justice systems.*
- *Each American paid \$277 per year in state taxes to deal with the burden of substance abuse and addiction within social programs, and only \$10 for prevention and treatment.*



Of the \$13.9 Billion in Washington State Government Spending in 1998, \$1.5 Billion (10.9%) was Spent on Services Related to Impacts of Substance Abuse.

***Distribution of State Spending
Related to Impacts of Substance Abuse***

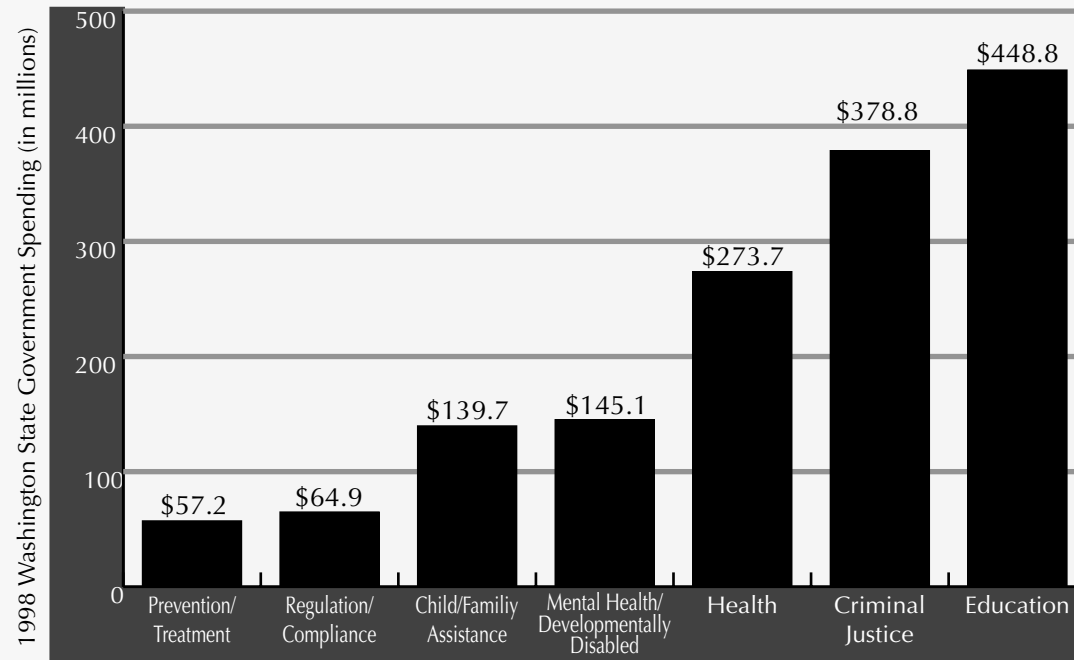
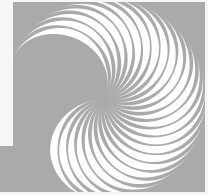


Source: Data from National Center on Addiction and Substance Abuse at Columbia University, *Shoveling Up: The Impact of Substance Abuse on State Budgets*, 2001.

In 1998, the \$1.51 billion of Washington State government spending related to the impacts of substance abuse compares with \$2.65 billion spent on higher education, \$1.46 billion spent on Medicaid, and \$1.09 billion spent on transportation.¹

¹ National Center on Addiction and Substance Abuse at Columbia University, *Shoveling Up: The Impact of Substance Abuse on State Budgets*. New York, NY: 2001.

Substance Abuse Results in Significantly Higher State Government Spending on Education, Criminal Justice, and Health.



Source: Data from National Center on Addiction and Substance Abuse at Columbia University, *Shoveling Up: The Impact of Substance Abuse on State Budgets*, 2001.

In 1998, 10% of Washington State government spending, or \$248 for every resident, was related to impacts of substance abuse. Only approximately \$10 of this amount went for prevention and treatment.¹

The Problem: Substance Abuse Prevalence & Trends

PREVALENCE

Adolescent
Substance
Use and Beliefs

Adult
Substance
Use

The Problem: Substance Abuse Prevalence & Trends

PREVALENCE

Adolescent
Substance Use
and Beliefs

Adult
Substance
Use



Washington's Healthy Youth Survey

In Washington State, multiple state agencies have been conducting surveys of youth health behavior since 1988. The surveys have been based on two different national surveys: Monitoring the Future supported by the National Institute on Drug Abuse; and the federal Centers for Disease Control and Prevention's Youth Risk Behavior Survey. In 1995, a Communities That Care survey, developed by the University of Washington, became an important component of the survey effort, integrating risk and protective factors. More recently, a Youth Tobacco Survey was incorporated.

To better coordinate these survey efforts, and to prevent the need for survey data from becoming an undue burden on schools, interested state agencies – Office of Superintendent of Public Instruction; Department of Social and Health Services' Division of Alcohol and Substance Abuse; Department of Health's Tobacco Control Program and Maternal and Child Health Program; Department of Community, Trade & Economic Development, Community Mobilization; and the Family Policy Council – resolved to cooperate on the administration of a single survey of youth behaviors every two years, to be administered in the fall.

The goals of this collaborative effort are:

- To describe youth health behavior, habits, risks, and outcomes; and
- To describe school, community, family, and peer/individual risk and protective factors.

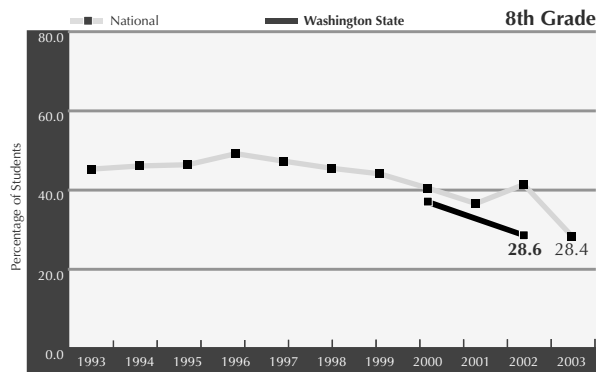
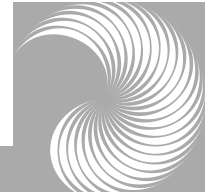
To achieve these goals, it was agreed that the survey must:

- Gather state-level data in a consistent manner (with predictable timing and using comparable measures over time); and
- Support local-level data collection and use for planning, assessment, and evaluation of programs to serve youth.

The data represented on the following pages are from the Healthy Youth Survey, which represents the result of these collaborative efforts. Complete data from the Healthy Youth Survey are available on-line at the Washington State Department of Health's website: www3.doh.wa.gov/HYS/default.htm.

The Prevention Standing Committee of the Governor's Council on Substance Abuse has set a series of state targets for prevention efforts. These targets are continually revised as progress is made in improving the effectiveness of prevention strategies.

The Percentage of Students, Both in Washington and Nationally, Who Have Ever Smoked a Cigarette is Declining.*



Tobacco use is the leading cause of preventable illness and death in the United States.¹ A 1996 federal Centers for Disease Control and Prevention Study suggests that 33% of young smokers will eventually die as a result of tobacco use, if current use patterns continue.²

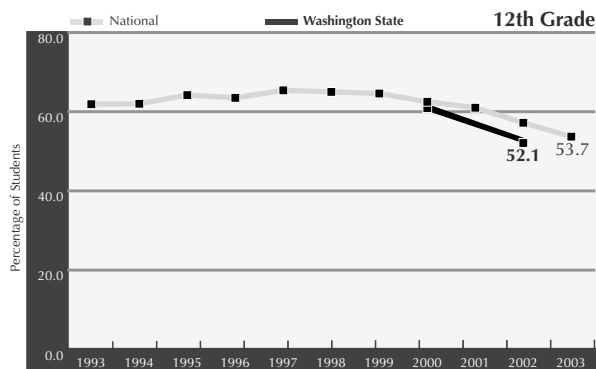
These graphs indicate that experimentation with tobacco is on the decline, both in Washington State and nationally. The state target is to raise the average age of adolescents' first use of tobacco products to 16.

¹ U.S. Surgeon General, *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000.

² Centers for Disease Control and Prevention, "Projected Smoking-Related Deaths Among Youth – United States," *Morbidity and Mortality Weekly Report* 45, 1999.



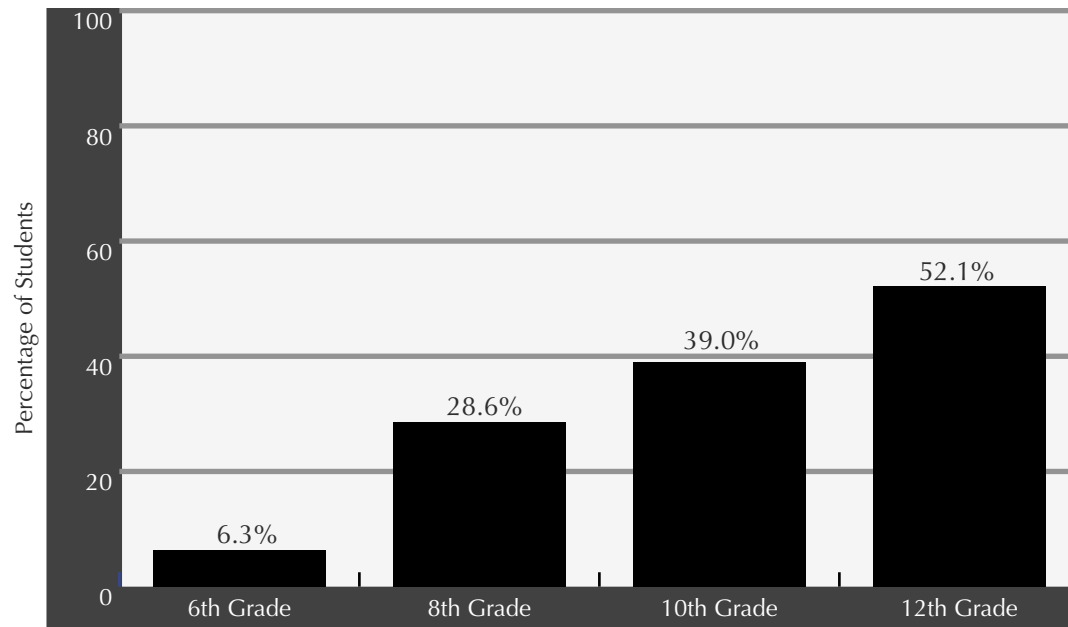
* The Washington State Healthy Youth Survey (HYS) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between HYS and MTF thus should not be made, except for the purpose of viewing trends.



Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey*.



By 12th Grade, More Than Half of Washington Adolescents Have Tried Smoking.



Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2002*.

The percentage of Washington State students who have experimented with smoking is declining. Experimentation and use of smokeless tobacco is also on the decline.¹

Research indicates that increasing tobacco taxes on cigarettes, when combined with anti-smoking campaigns, is one of the most cost-effective short-term strategies to prevent tobacco initiation about youth.² A recent study found that 70% of U.S. youths ages 14-17 report they can purchase cigarettes within five blocks of their home.³ However, the Washington State Healthy Youth Survey found that only 17% of 10th grade youth reported they usually obtained tobacco by purchasing it themselves; 66% obtained it from others.⁴

¹ Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2002*. Olympia, WA: 2003.

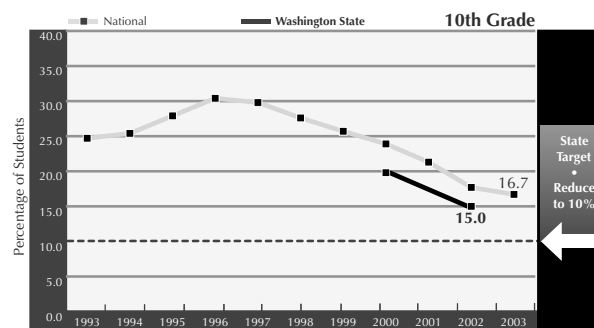
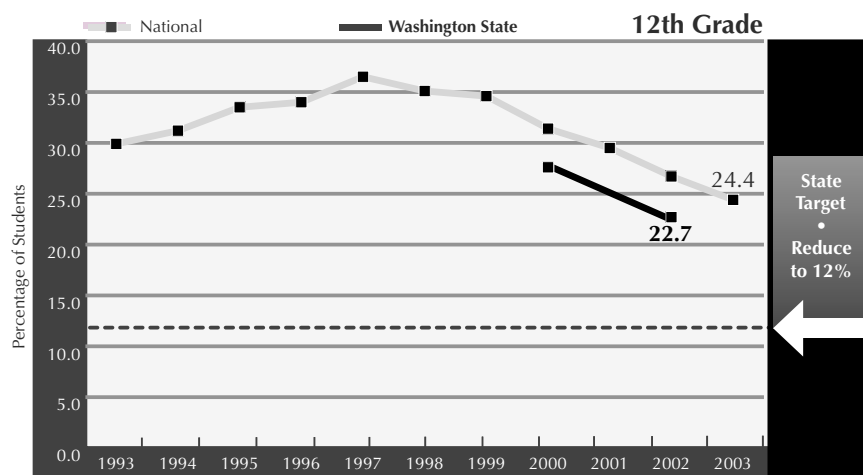
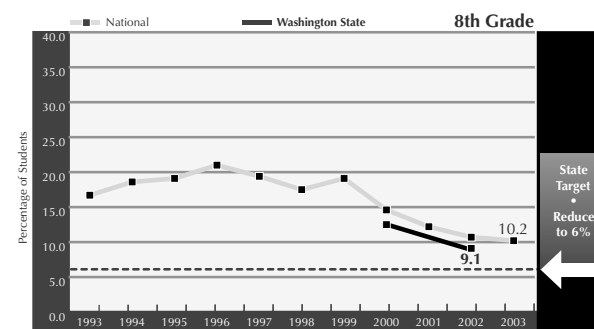
² U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 27-6. Washington, DC: 2000.

³ Institute for Adolescent Risk Communication, *Access to Risky Products and Perceptions of Risky Behavior and Popularity*. Philadelphia, PA: University of Pennsylvania, Annenberg Public Policy Center, 2002.

⁴ *Healthy Youth Survey*, op. cit.

In 2002, Washington State 8th, 10th, and 12th Graders were Less Likely to Have Smoked a Cigarette in the Past 30 Days than Their National Counterparts.*

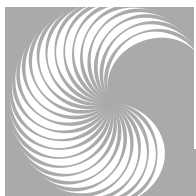
Recent smoking by adolescents appears to be on the decline, both in Washington State and nationwide. Studies indicate that youth and young adult smokers are more price-responsive than other smokers, and that a 10% increase in price could reduce the number of teenagers who smoke by 7%.¹



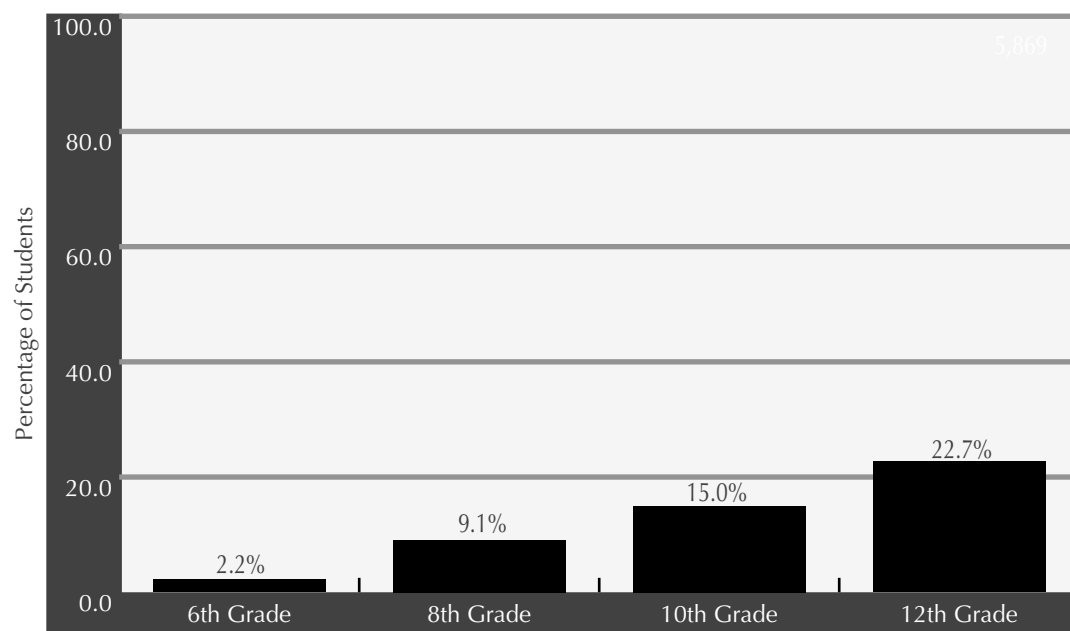
Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey*.

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¹ Schneider Institute for Health Policy, Brandeis University, *Substance Abuse – The Nation's Number One Health Problem: Key Indicators for Policy – Update February 2001*. Princeton, NJ: The Robert Wood Johnson Foundation, 2001.



Almost a Quarter of Washington High School Seniors Report Having Smoked a Cigarette in the Past 30 Days.



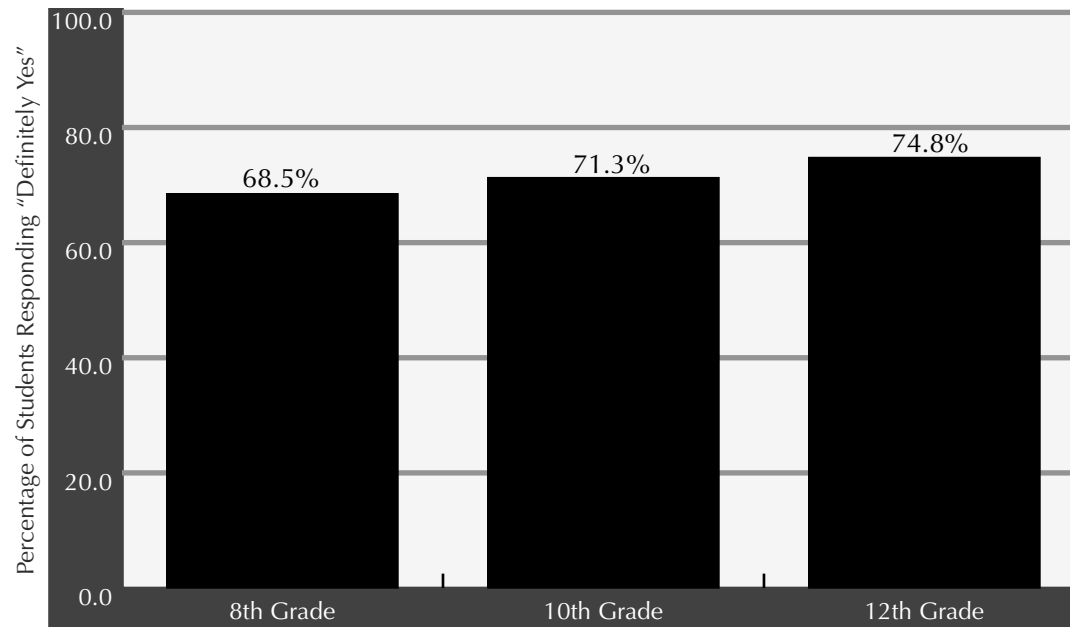
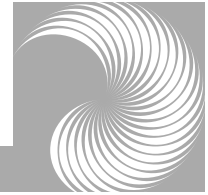
Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2002*.

Among young people, short-term health consequences of smoking include respiratory and non-respiratory effects, nicotine addiction, and the associated risk of other drug use. Long-term health consequences of youth smoking are reinforced by the fact that most young people who begin to smoke regularly in their youth continue to do so as adults.¹ A large majority of Washington State students who smoke report that they want to quit, and more than half have tried to stop during the previous year.²

¹ U.S. Surgeon General, *Tobacco Use Among Young People – A Report of the Surgeon General*. Washington, DC: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1994.

² Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2002*. Olympia, WA: 2003.

In 2002, Most Washington State Students Believe that Young People Risk Harming Themselves by Smoking 1-5 Cigarettes Per Day.

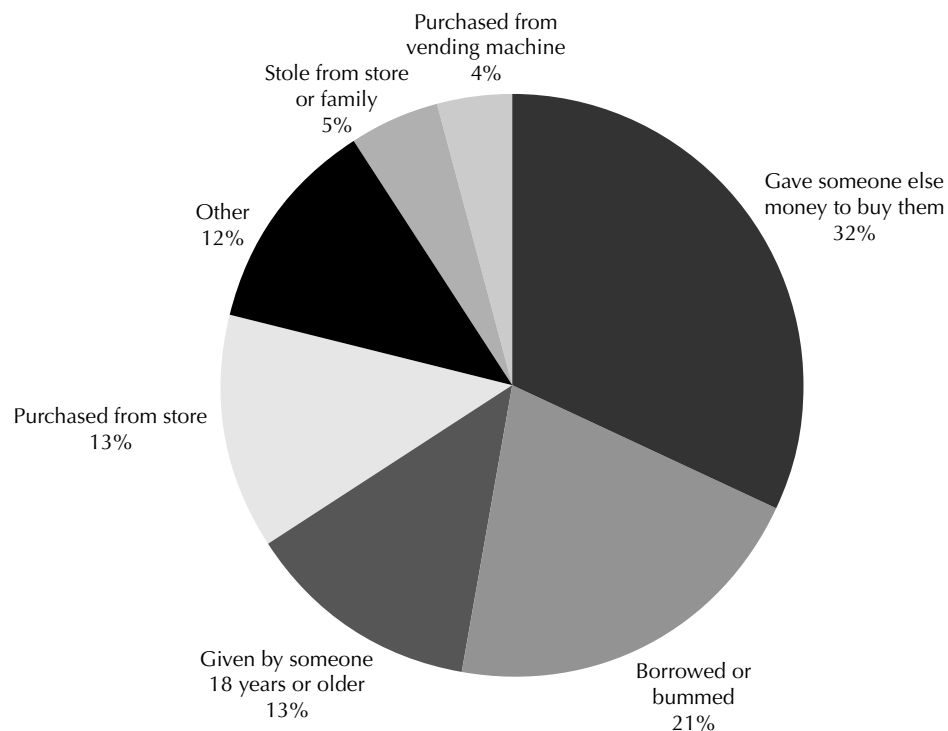


Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2002*.

Most Washington State students perceive a high degree of risk from smoking cigarettes. The percentage perceiving such risk rises as students get older, even as the rate of smoking among students increases. This suggests that new efforts need to be focused on helping current young smokers quit. A large majority of Washington State youth smokers report they would like to quit.¹



Most 10th Grade Smokers in Washington State Obtain Cigarettes from Others.

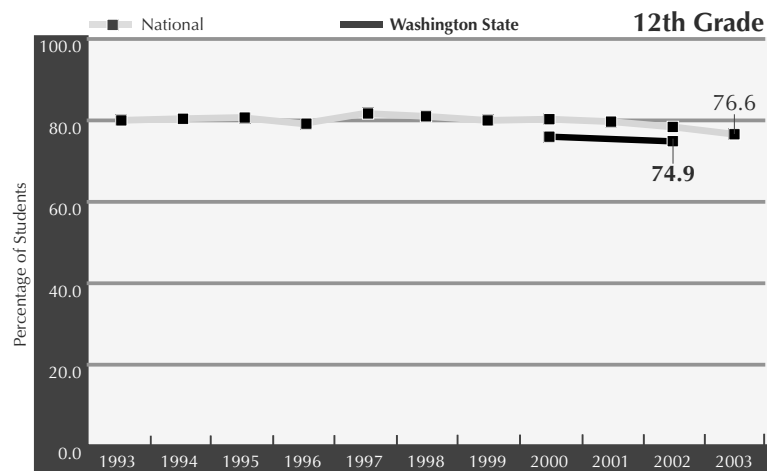


Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2002*.

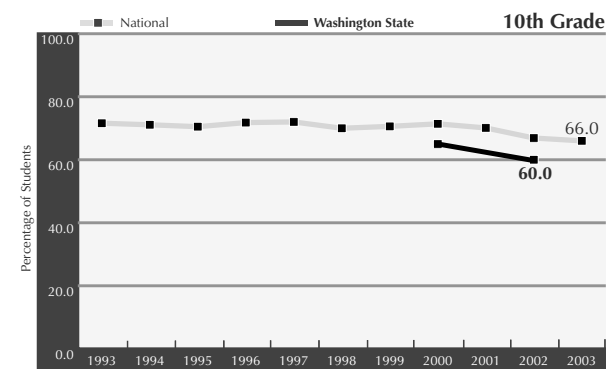
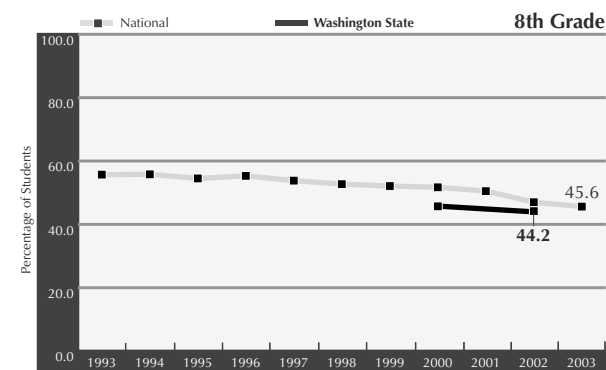
Only 17% of cigarettes obtained by Washington State 10th graders are purchased directly by them. The rest are obtained for them by others. This suggests that there is a culture around smoking that still makes it socially acceptable for others to participate in young people developing a highly dangerous health habit.

The Percentage of Students, Both in Washington and Nationally, Who Have Tried Alcohol is Declining.*

In 1999, underage drinkers (ages 12-20) consumed 19.7% of alcohol consumed in the United States, accounting for \$22.5 billion in total alcohol sales. Roughly half of youth in this age group drink, a proportion similar to that of adults ages 21 and older.¹ The state target is to raise the average age of adolescents' first use of alcohol to 16.

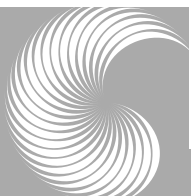


Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey*.

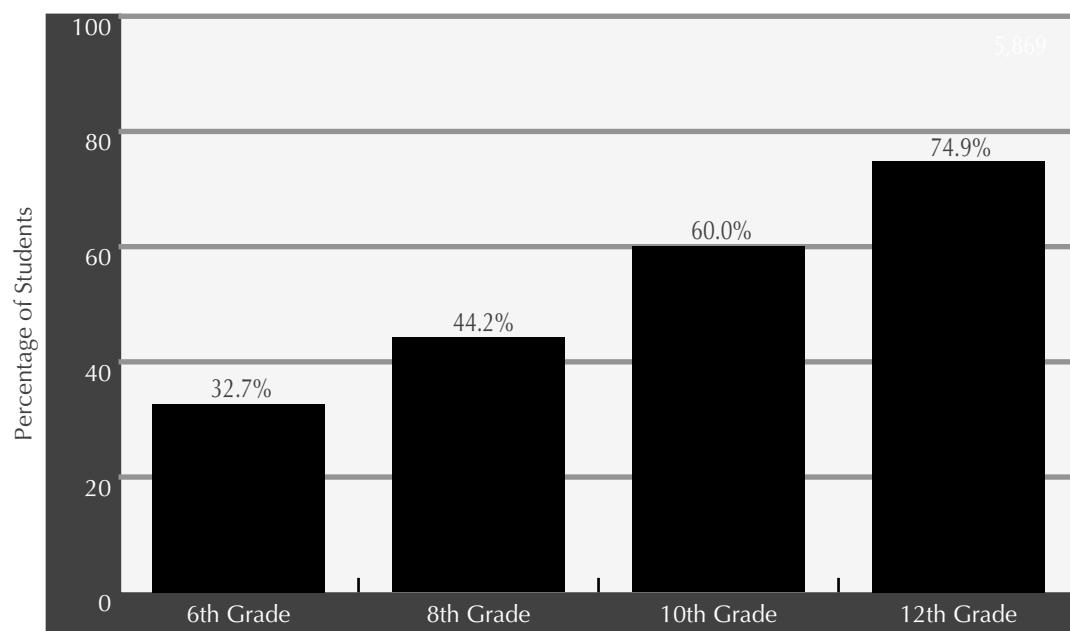


* The Washington State Healthy Youth Survey (HYS) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between HYS and MTF thus should not be made, except for the purpose of viewing trends.

¹ Foster, S., et al., "Alcohol Consumption and Expenditures for Underage Drinking and Adult Excessive Drinking," *Journal of the American Medical Association* 289(8), 2003.



Almost a Third of Washington 6th Graders Have Tried Alcohol.



Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2002*.

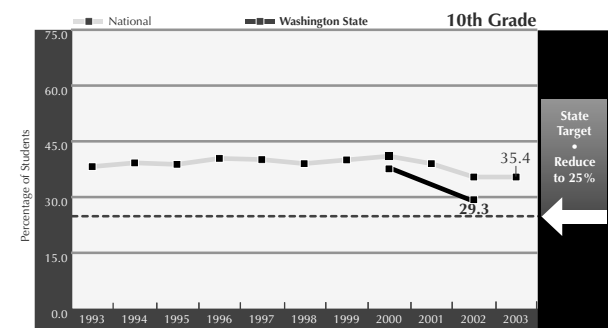
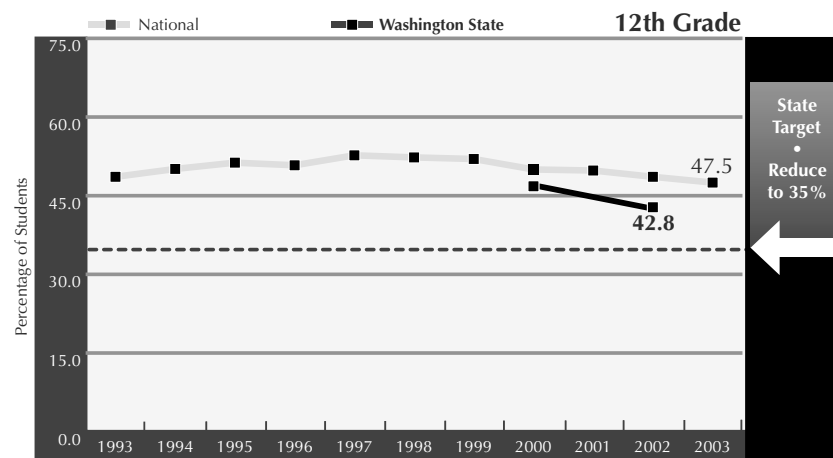
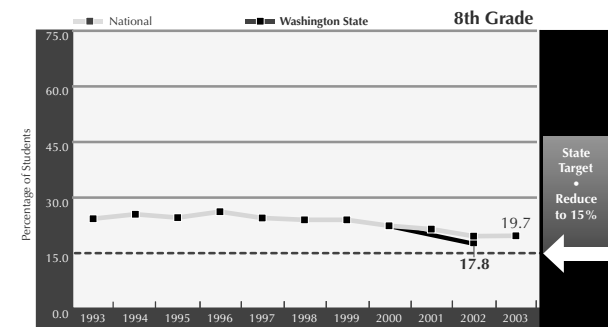
Teenage drinking can physically damage the brain; interfere with mental and social development; interrupt academic progress; increase chances of risky sexual behavior and teen pregnancy, juvenile delinquency, and crime; compromise health; and result in unintentional injury and death.¹

Almost half of Washington students have tried alcohol before they reach high school.

¹ Foster, S., et al., "Alcohol Consumption and Expenditures for Underage Drinking and Adult Excessive Drinking," *Journal of the American Medical Association* Vol. 289 No. 8, February 26, 2003.

Use of Alcohol in the Past 30 Days by Washington State 8th, 10th, and 12th Graders is Declining.*

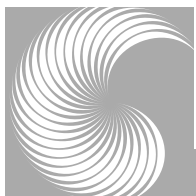
Recent alcohol use among youth appears to be dropping, both nationally and in Washington State. Research indicates that initiation of alcohol use at an early age increases the risk that teenagers will become adult heavier drinkers with alcohol-related problems later in life.¹



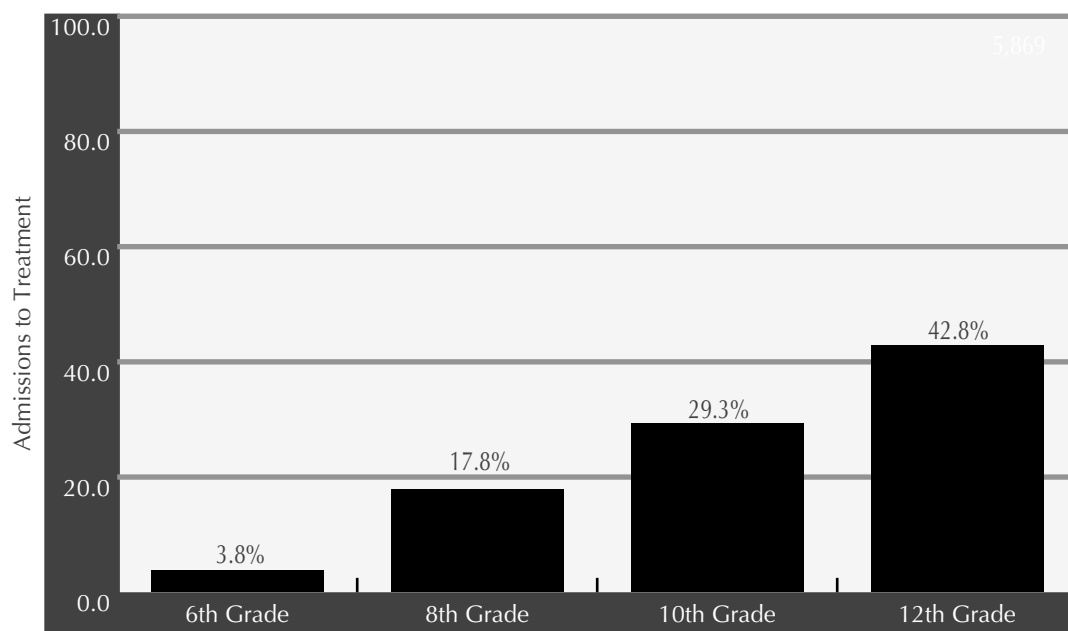
Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey*.

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¹ Dewit, D., et al., "Age at First Alcohol Use: A Risk Factor for the Development of Alcohol Disorders," *American Journal of Psychiatry* 157, 2000; Grant, B., and Dawson, D., "Age at Onset of Alcohol Use and Its Association with DSM-IV Alcohol Abuse and Dependence: Results from the National Longitudinal Alcohol Epidemiologic Survey," *Journal of Substance Abuse* 9, 1997.



Almost One Out of Five Washington 8th Graders Report Having Used Alcohol in the Past 30 Days.



Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2002*.

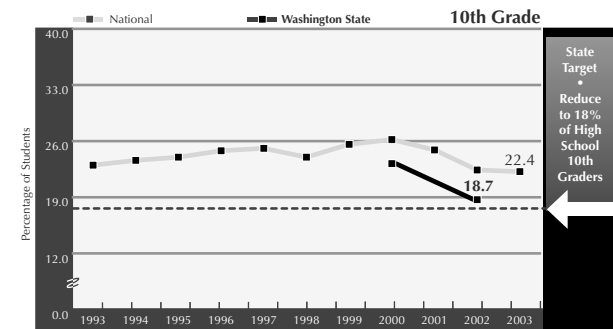
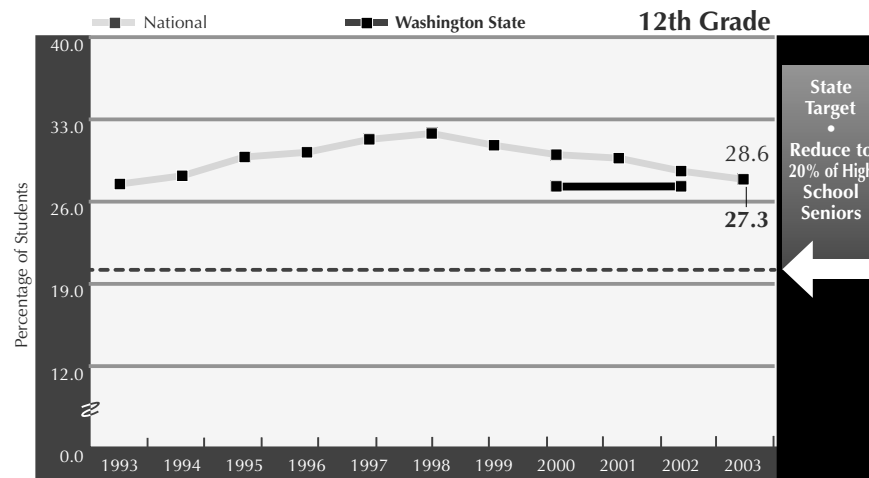
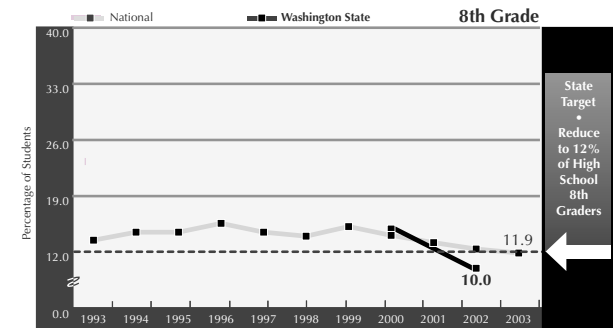
A recent study indicates that youth ages 12-20 are responsible for 19.7% of all alcohol consumed in the United States.¹ Despite the fact that it is illegal, more than 40% of Washington high school seniors report using alcohol in the past 30 days. Teenage drinking is associated with a full range of academic, social, and medical consequences, including juvenile delinquency and crime, risky sexual behavior and teen pregnancy, poor academic progress and school dropout rates, and unintentional injuries and death.²

¹ Foster, S., et al., "Alcohol Consumption and Expenditures for Underage Drinking and Adult Excessive Drinking," *Journal of the American Medical Association* 288 (8), February 26, 2003.

² *Ibid.*

Recent Binge Drinking by Washington State 8th, 10th, and 12th Graders is Declining.*

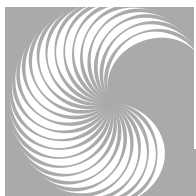
These graphs indicate that in 2002, the percentage of Washington State students engaging in recent binge drinking declined. Recent binge drinking is defined as having five or more drinks in a row on at least one occasion in the past two weeks.



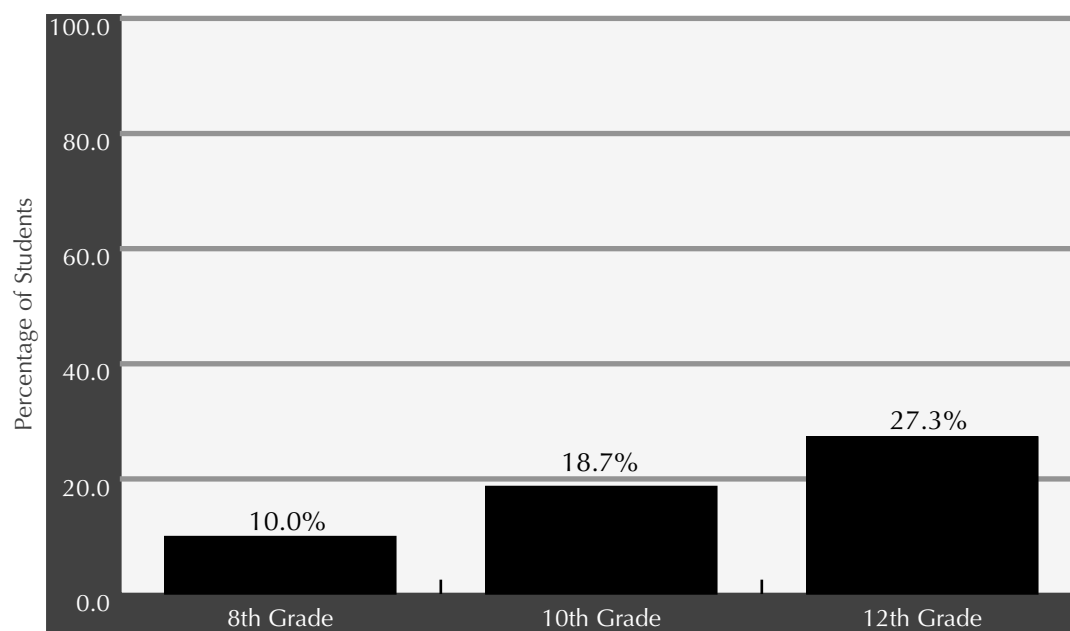
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¹ Institute for Adolescent Risk Communication, *Access to Risky Products and Perceptions of Risky Behavior and Popularity*. Philadelphia, PA: University of Pennsylvania, Annenberg Public Policy Center, 2002.



More Than a Quarter of Washington Seniors Have Engaged in Recent Binge Drinking.

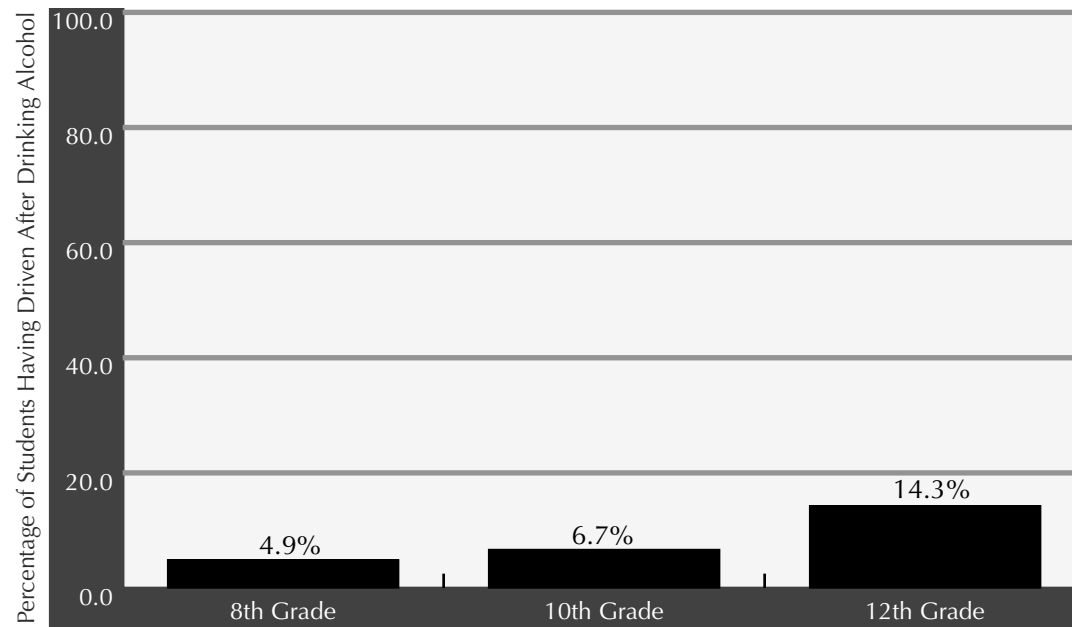
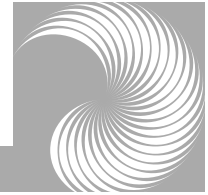


Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2002*.

Recent binge drinking is defined as consuming five or more drinks in a row on at least one occasion in the past two weeks. A 2000 survey of Washington students indicates that binge drinking may start as early as the 6th grade, or earlier.¹ Heavy drinking among youth has been linked to motor vehicle crashes and deaths, physical fights, property destruction, poor school and employment performance, and involvement with law enforcement and the legal system.

¹ Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors – 2000*. Olympia, WA: 2000.

In 2002, Almost 5% of Washington State 8th Graders Had Driven a Vehicle After Drinking Alcohol.



Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2002*.

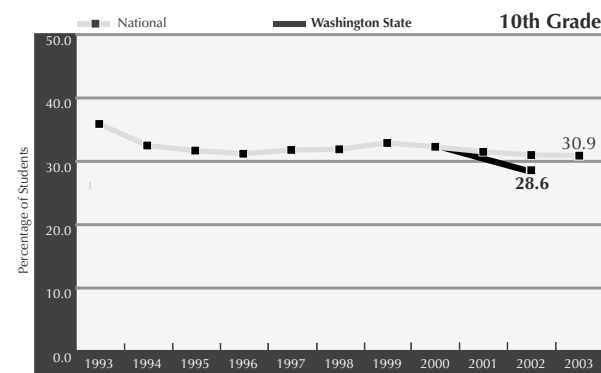
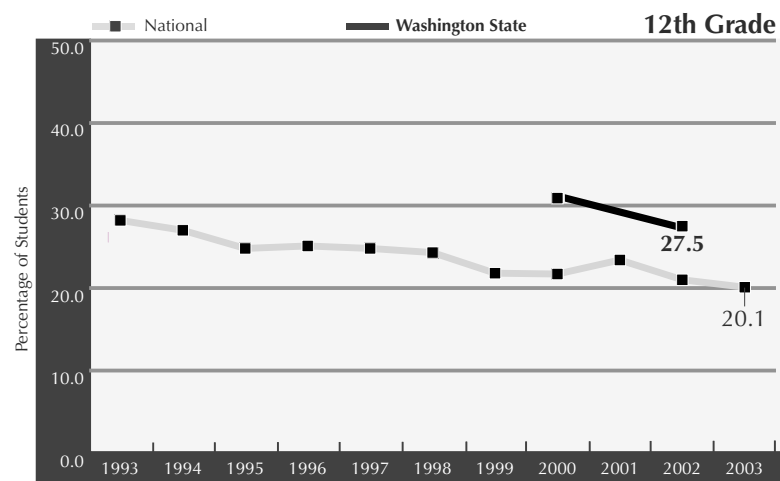
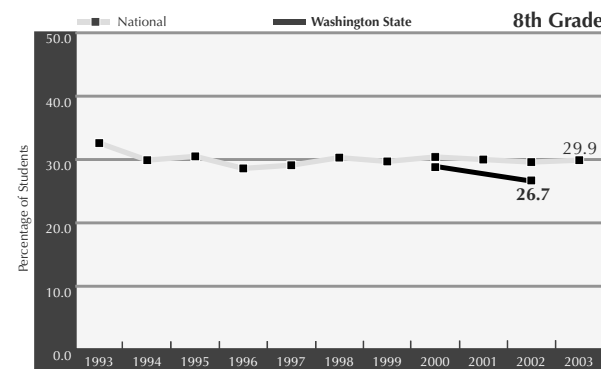
The *Washington State Healthy Youth Survey* allows for the cross-tabulation of substance abuse among students with other behaviors in schools and communities. Significant percentages of Washington students in 8th, 10th, and 12th grades have driven after drinking alcohol. This is true even among students too young to possess a drivers license.

According the National Highway Traffic Safety Administration, 3,594 drivers ages 15-20 died in motor vehicle crashes in 2000. Some 1,066 (29%) had been drinking, and 21% were legally drunk at the time of the crash.¹



The Percentage of Washington State Students in 8th, 10th, and 12th Grade Who Perceive Great Risk from Drinking 1-2 Alcohol Drinks Nearly Every Day Appears to Be Declining.

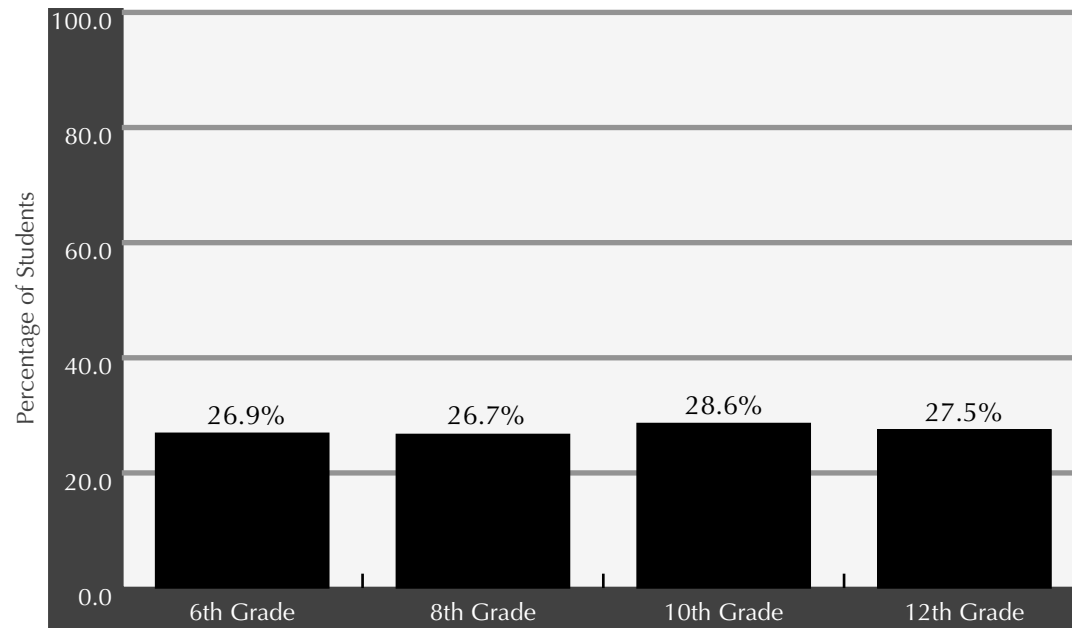
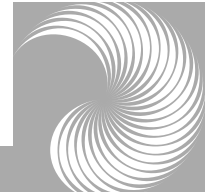
This graph indicates that almost three-quarters of Washington State 8th, 10th, and 12th grade students do not perceive great risk in near-daily alcohol consumption. National data indicate that student perception of risk regarding both regular use of alcohol and heavy drinking is declining, perhaps suggesting that alcohol use is becoming more acceptable among students.



Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey*.

* The Washington State Healthy Youth Survey (HYS) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between HYS and MTF thus should not be made, except for the purpose of viewing trends.

Only About a Quarter of Washington State 6th, 8th, 10th, and 12th Graders Perceive Great Risk from Drinking 1-2 Alcoholic Drinks Nearly Every Day.*



Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2002*.

Research indicates that attitudes about specific drugs and alcohol are among the most important determinants of actual use.¹ Perception of great risk from near-daily use of alcohol among Washington State students actually declined at all grades levels from the *Washington State Survey of Adolescent Risk Behaviors – 2000*. This may be due to the fact that, despite repeated prevention messages delivered in the school environment, students are barraged with advertising messages actively promoting alcohol use.

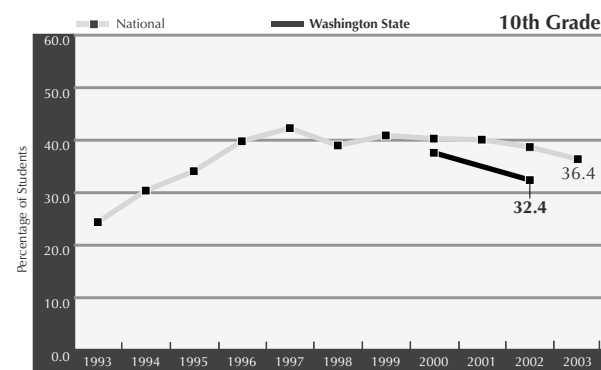
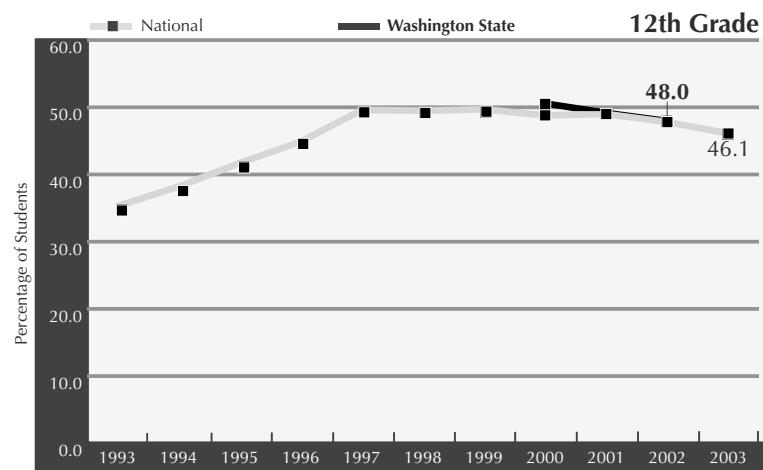
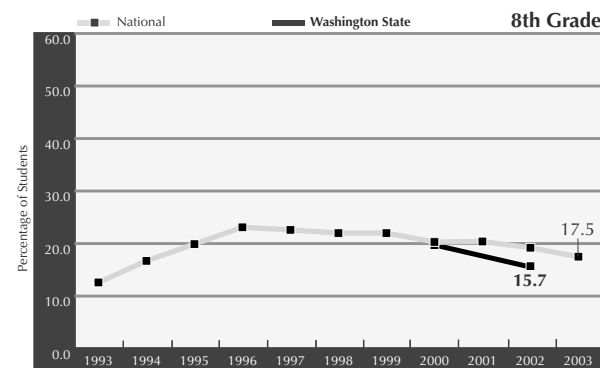
¹ Bachman, J., Johnston, L., and O'Malley, P., "Explaining Recent Increase in Students' Marijuana Use: Impacts of Perceived Risks and Disapproval," *American Journal of Public Health* 88 (6), 1988.



The Percentage of Students in Washington State Who Have Tried Marijuana is Declining.*

Besides being associated with a variety of health risks, marijuana use can contribute to risky behaviors and adverse physical and social consequences. Marijuana use among students in Washington State appears to be on the decline.

A national study indicates that 36% of youth ages 14-17 report they can purchase illegal drugs within five blocks of their home.¹ The state target is to raise the average age of adolescents' first use of marijuana to 16.

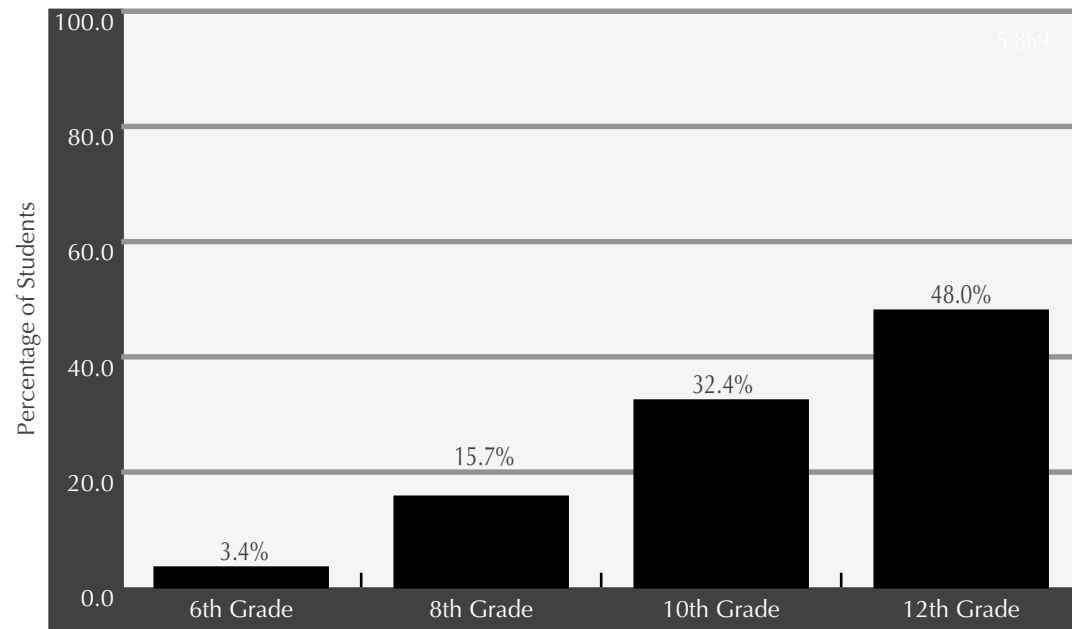
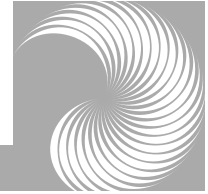


Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey*.

* The Washington State Healthy Youth Survey (HYS) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between HYS and MTF thus should not be made, except for the purpose of viewing trends.

¹ Institute for Adolescent Risk Communication, *Access to Risky Products and Perceptions of Risky Behavior and Popularity*. Philadelphia, PA: University of Pennsylvania, Annenberg Public Policy Center, 2002.

By 12th Grade, About Half of Washington Students Have Tried Marijuana.



Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2002*.

About one-fifth of Washington students begin use of marijuana while they are in middle school. A study conducted by the National Center on Addiction and Substance Abuse at Columbia University (CASA) found that substance abuse and addiction nationally added \$41 billion, or 10%, to the cost of elementary and secondary education in 2001 due to class disruption and violence, special education and tutoring, teacher turnover, children being left behind, student assistance programs, property damage, injury, and counseling.

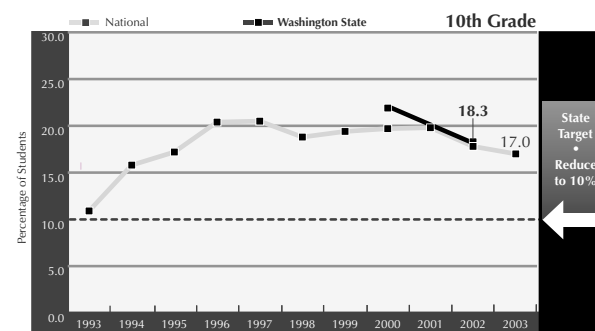
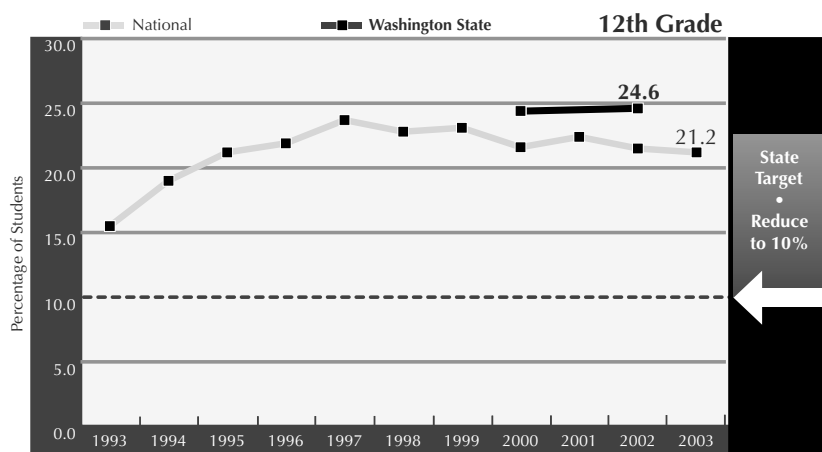
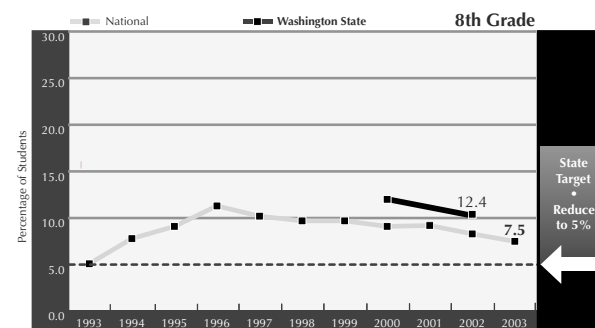
CASA also estimates that 60% of high school students and 30% of middle school students attend schools where illegal drugs are kept, sold, and used. Among 10th graders surveyed, 87% said it was easy to get tobacco, 88% to obtain alcohol, and 78% to get marijuana.¹

¹ *Malignant Neglect: Substance Abuse and America's Schools*. New York, NY: The National Center on Addiction and Substance Abuse at Columbia University, 2001.



After Rising Throughout the 1990s, Marijuana Use in the Past 30 Days Among 8th, 10th, and 12th Graders is Beginning to Decline.*

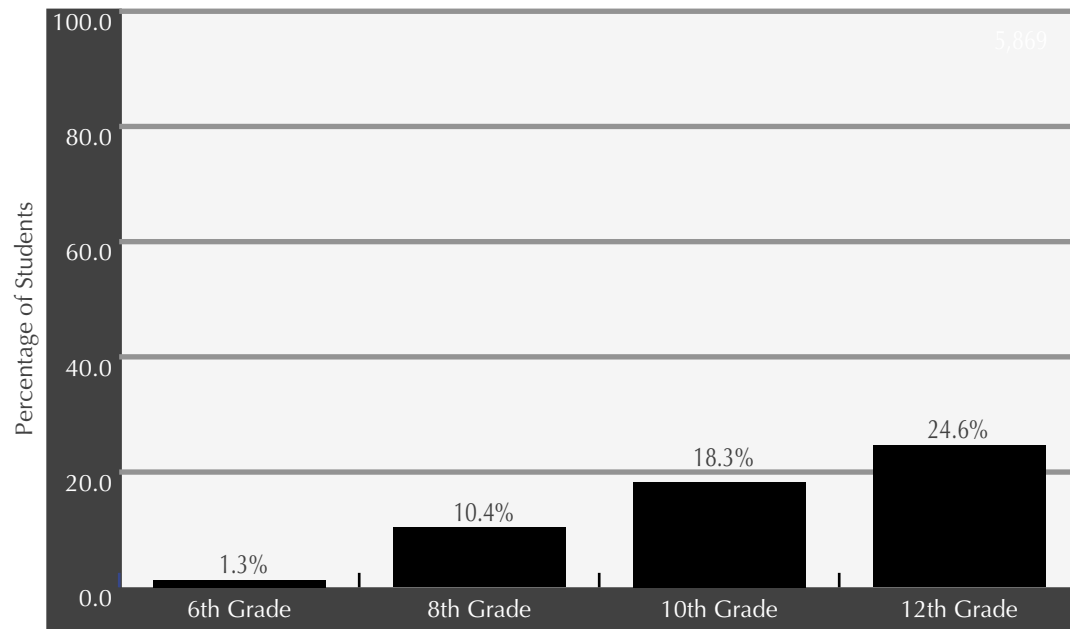
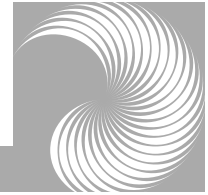
Both nationally and in Washington State, after almost a decade of increases, marijuana use among 8th, 10th, and 12th graders appears to have peaked, and is now beginning to decline.



Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey*.

* The Washington State Healthy Youth Survey (HYS) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between HYS and MTF thus should not be made, except for the purpose of viewing trends.

About One Quarter of Washington Seniors Report Having Used Marijuana in the Past 30 Days.



Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2002*.

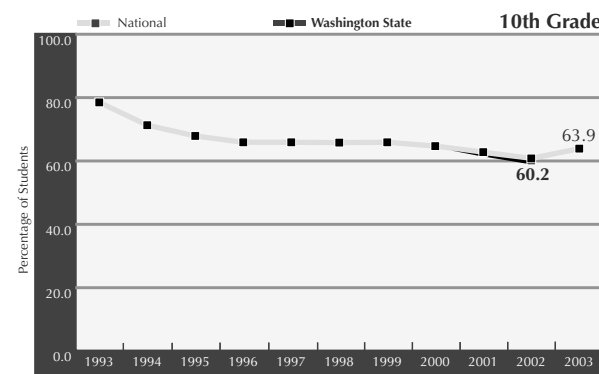
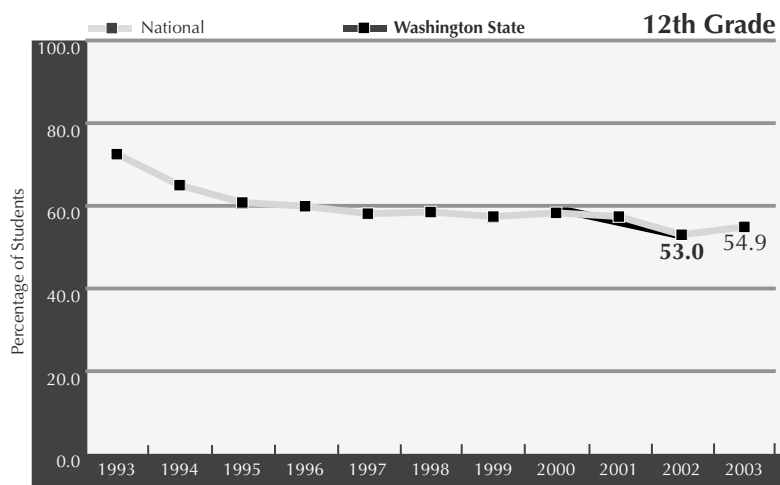
Marijuana use among adolescents follows a predictable pattern, with the highest incidence of use occurring among high school seniors. *Healthy People 2010* recommends a multicomponent approach to youth substance abuse prevention to increase the effectiveness of efforts. Such an approach would include focusing on mobilizing and leveraging resources, raising public awareness, and countering pro-use messages.¹

¹ U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 26-28. Washington, DC: 2000.



Nationally, the Percentage of 8th, 10th, and 12th Graders Who Perceive Great Risk from Regular Marijuana Use Has Declined Over the Past Decade.*

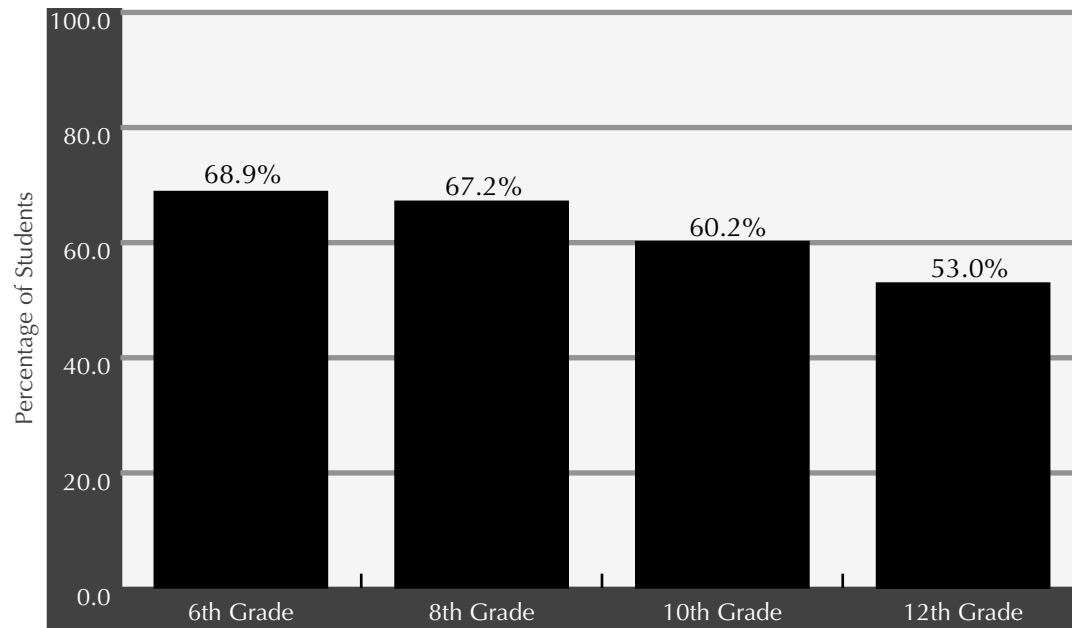
Perception of risk from regular marijuana use has been declining among 8th, 10th, and 12th grade students, and is close to its lowest point since 1980.



Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey*.

* The Washington State Healthy Youth Survey (HYS) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between HYS and MTF thus should not be made, except for the purpose of viewing trends.

The Percentage of Washington State Students Who Perceive Great Risk from Marijuana Use Declines as They Get Older.

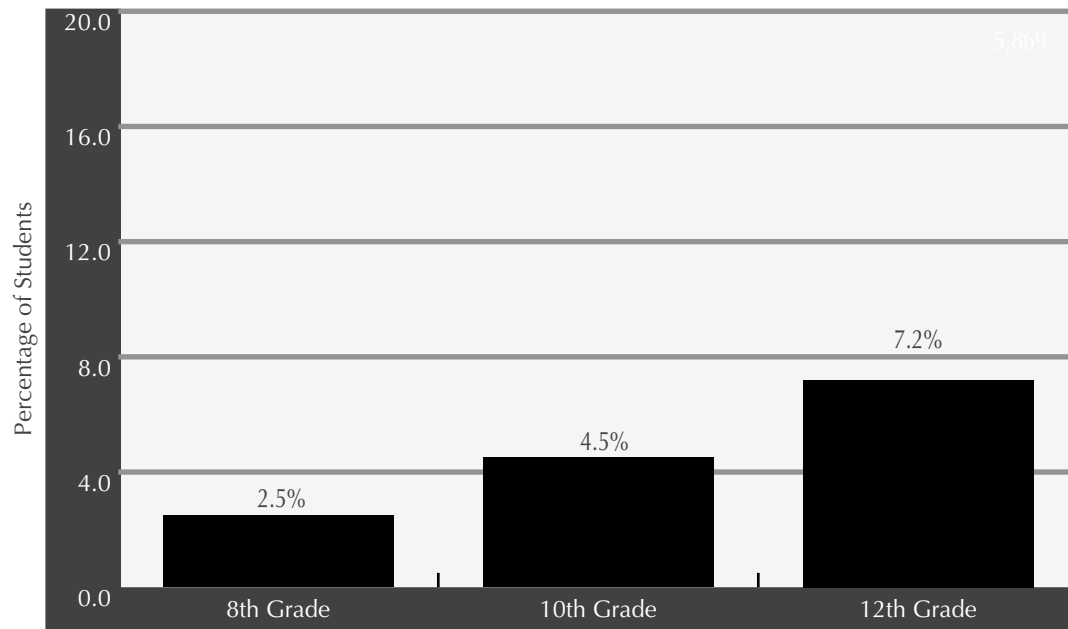


Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2002*.

The percentage of students, both in Washington State and nationally, who perceive great risk from regular marijuana use declines as they get older. This is contrary to the way students perceive the risk of regular cigarette use, which increases as students get older. In 2002, at all grade levels, a lower percentage of Washington State students perceived great risk from regular marijuana use than in 2000.



In 2002, More than 7% of Washington State High School Seniors Reported Having Tried Methamphetamine.

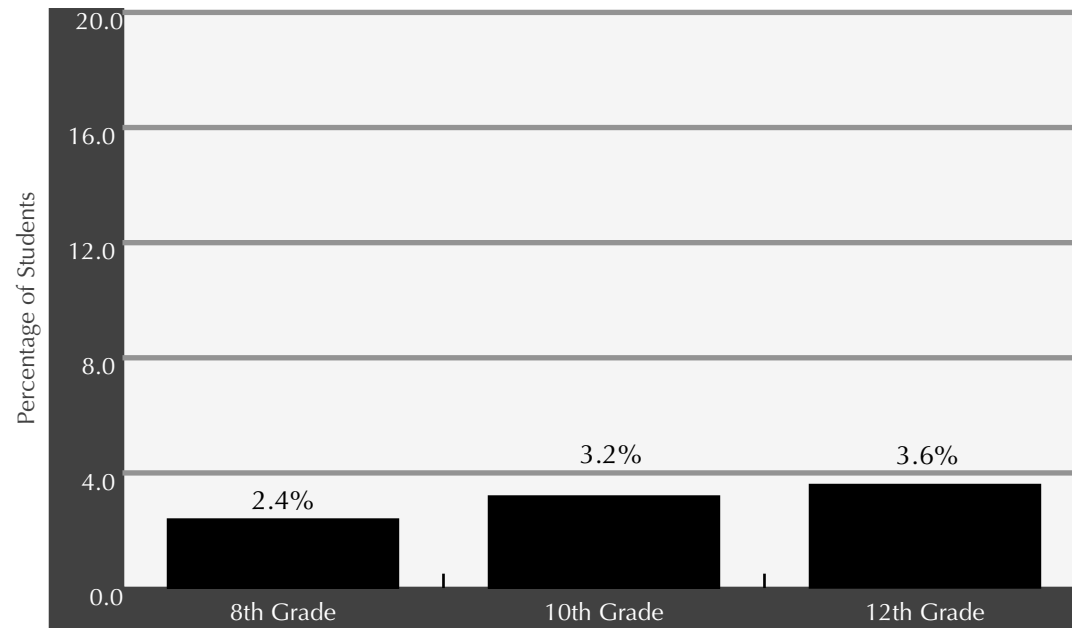
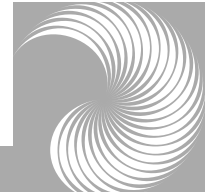


Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2002*.

Researchers funded by the National Institute on Drug Abuse have found a range of negative cognitive effects from use of methamphetamine, often associated with brain cell damage. Some of this damage is long-term, and users may not fully recover after they have become abstinent.¹ Recent data from the Washington State Healthy Use Survey suggest that lifetime methamphetamine use among Washington State teenagers may have peaked.

¹ National Institute on Drug Abuse, "Brain Imaging Studies Show Long-Term Damage from Methamphetamine Abuse," *NIDA Notes* 15(3), August 2000; National Institute on Drug Abuse, "Methamphetamine Abuse Linked to Impaired Cognitive and Motor Skills Despite Recovery of Dopamine Transporters," *NIDA Notes* 17(1), April 2002.

In 2002, 3.6% of Washington State High School Seniors Reported Having Used MDMA/Ecstasy in the Past 30 Days.

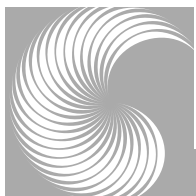


Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2002*.

MDMA/Ecstasy, one of a variety of substances called “club” or “party” drugs because of where they are often ingested, has been shown to produce long-lasting damage to the neurons that release serotonin, and may be associated with depression, sleep disorders, anxiety, and memory impairment.¹ The Washington State Healthy Youth survey indicates that in 2002 some 13.5% of Washington high school seniors have experimented with MDMA/Ecstasy at least once.²

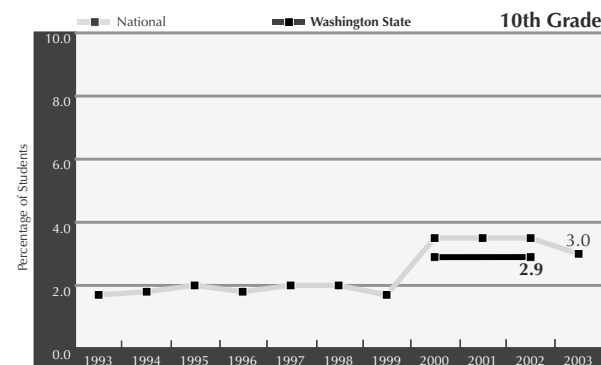
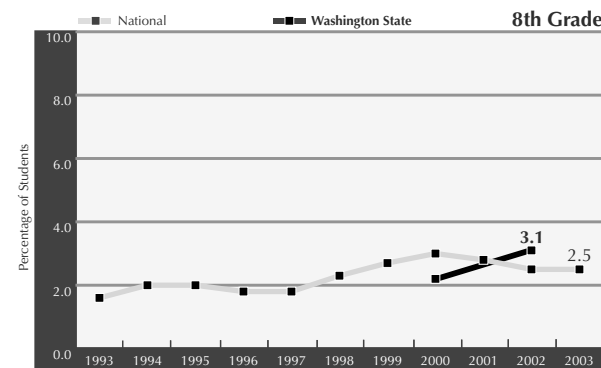
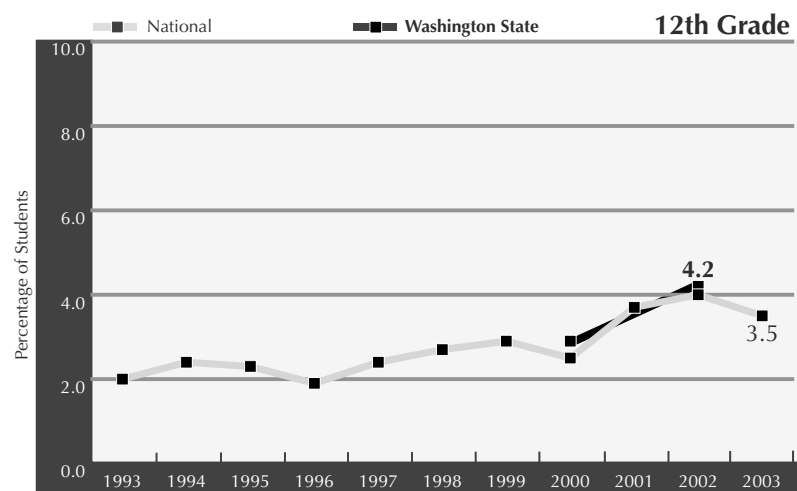
¹ National Institute on Drug Abuse, *NIDA Community Drug Alert Bulletin – Club Drugs*, December 1999.

² Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2002*. Olympia, WA: 2003.



In 2002, More than 4% of Washington State High School Seniors Reported Having Used Steroids at Least Once.*

Behavioral and health problems associated with steroid use include suicides, homicides, liver damage, and heart attacks.¹ Lifetime use of steroids in Washington State appears to be increasing among high school students, and age of first use is declining. While substantially more males (6.3% of Washington high school seniors) than females (2.3% of Washington high school seniors) have tried steroids, use among female high school students may be increasing as well.

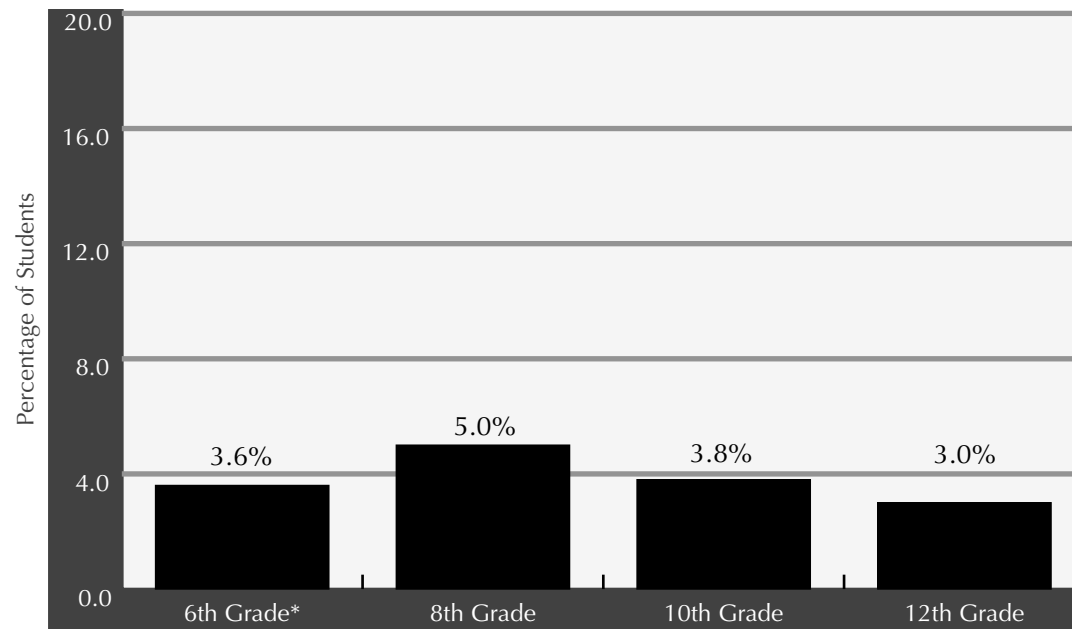
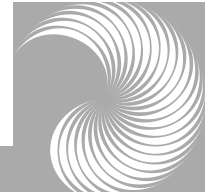


Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey*.

* The Washington State Healthy Youth Survey (HYS) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between HYS and MTF thus should not be made, except for the purpose of viewing trends.

¹ U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 26-36. Washington, DC: 2000.

Use of Inhalants in the Past 30 Days Among Washington State Students Peaks in the 8th Grade.



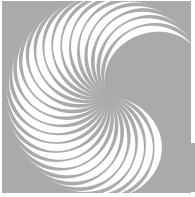
Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2002*.

Inhalants are substances whose vapors can be inhaled to produce a mind-altering effect. They include volatile solvents (paint thinners, degreasers, and glues); aerosols (hair sprays and vegetable oil sprays); ether, nitrous oxide, and propane; and nitrites. A single, prolonged session of inhalant use can produce rapid and irregular heart rhythms, heart failure, and death. Chronic exposure can cause widespread and long-lasting damage to the nervous system and other vital organs.¹

In 2002, Washington State 8th graders reported the highest use of inhalants in the previous 30 days. Thereafter, unlike the pattern for other drug and alcohol use, inhalant use declines.

*6th grade percentage is for lifetime use; other grades are for past 30-day use.

¹ National Institute on Drug Abuse, "Facts About Inhalant Abuse," *NIDA Notes* 15 (6), January 2001.



Peer Substance Abuse Has Significant Negative Impacts on School Performance.

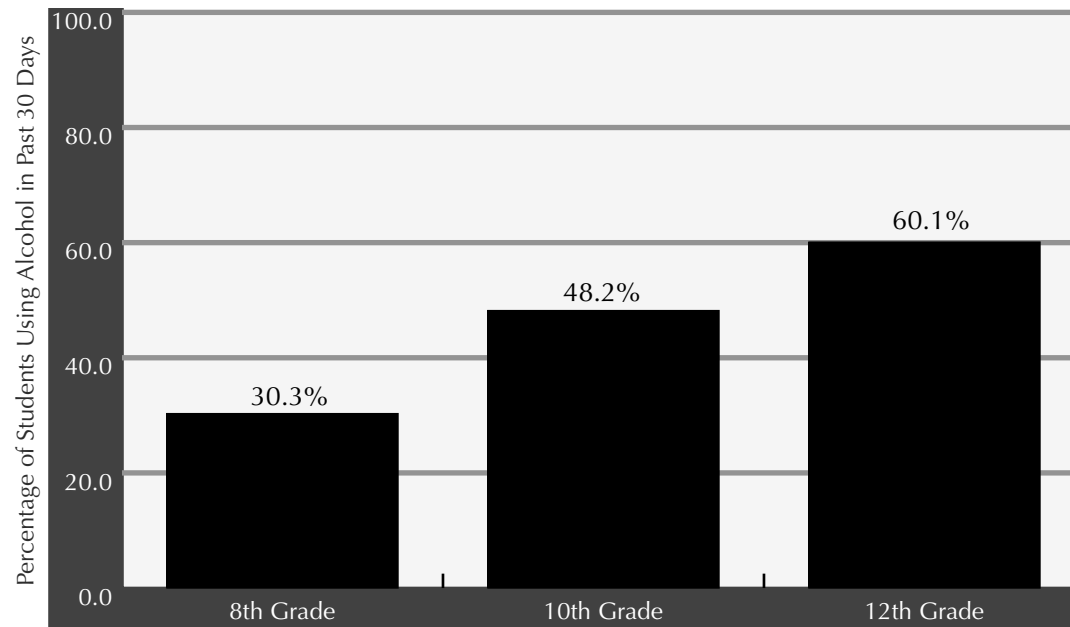
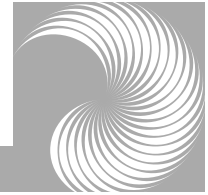
In a study undertaken by Washington Kids Count at the University of Washington's Human Services Policy Center, data from the results of the 1999 Washington Assessment on Student Learning tests were linked with the results of the 1998 Washington Survey of Adolescent Health Behaviors administered in Washington schools. Peer substance use was calculated as the average level of alcohol or drug use by students of the same age, gender, and race-ethnic group in the school.

Among middle schoolers:

- *Students whose peers had little or no involvement with drinking and drugs scored substantially higher than students whose peers had a low level of drinking or drug use.*
- *The entire average difference in whether or not students met the state reading and math standards was accounted for by the degree to which their peers used alcohol or other drugs.*
- *The most important factors reliably indicating the level of substance abuse in a school are whether students start antisocial behavior at an early age, whether the prevailing attitudes of the students condone or condemn antisocial behavior, and whether students have opportunities for productive involvement in school and community activities.¹*

¹Brandon, R., *Impact of Peer Substance Use on Middle School Performance in Washington: Summary*. Seattle, WA: University of Washington, Human Services Policy Center, Washington Kids Count, 2001.

Students Who Report Poor Grades are More Likely to Have Used Alcohol in the Past 30 Days.



Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2002*.

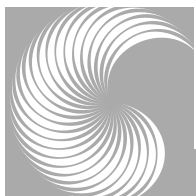
The Washington State Healthy Youth Survey allows for the cross-tabulation of substance abuse among students with other behaviors in schools and communities. Alcohol use in the past 30 days is associated with self-reported poor grades (grades last year of mostly D's and F's). In 2002, of 10th graders reporting poor grades, some 13.2% used alcohol ten or more times in the past 30 days. This association begins early, with 7.5% of 6th graders reporting poor grades having used alcohol in the past 30 days.

The Problem: Substance Abuse Prevalence & Trends

PREVALENCE

Adolescent
Substance
Use and Beliefs

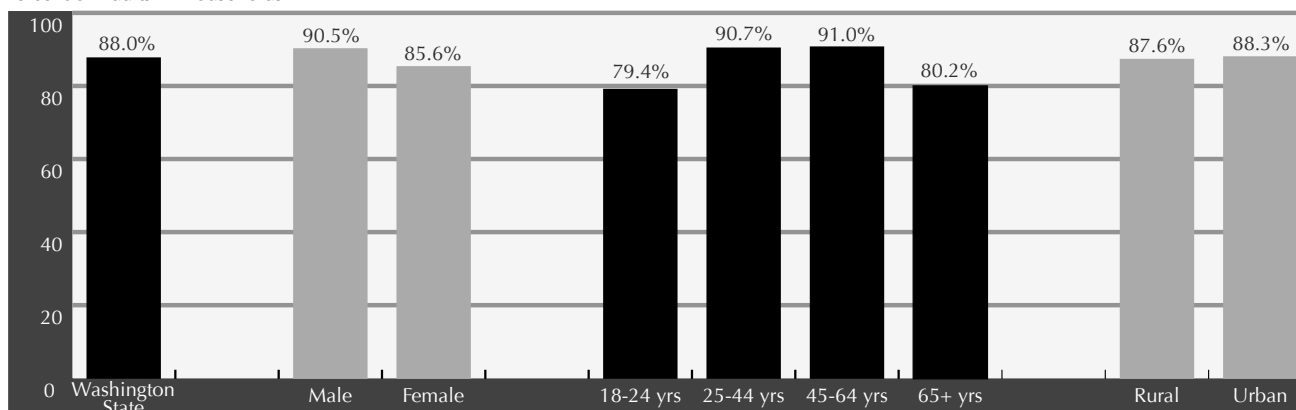
Adult
Substance
Use



Males and Individuals Ages 25-44 Have Higher Rates of Alcohol Use.

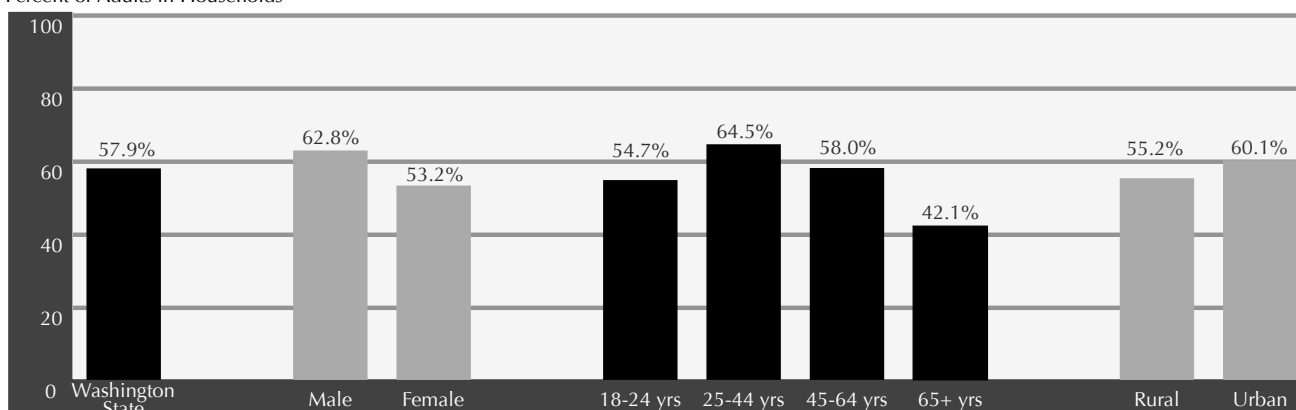
Lifetime Use of Alcohol

Percent of Adults in Households



Past 30-Day Use of Alcohol

Percent of Adults in Households

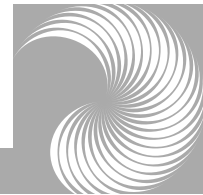


Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.

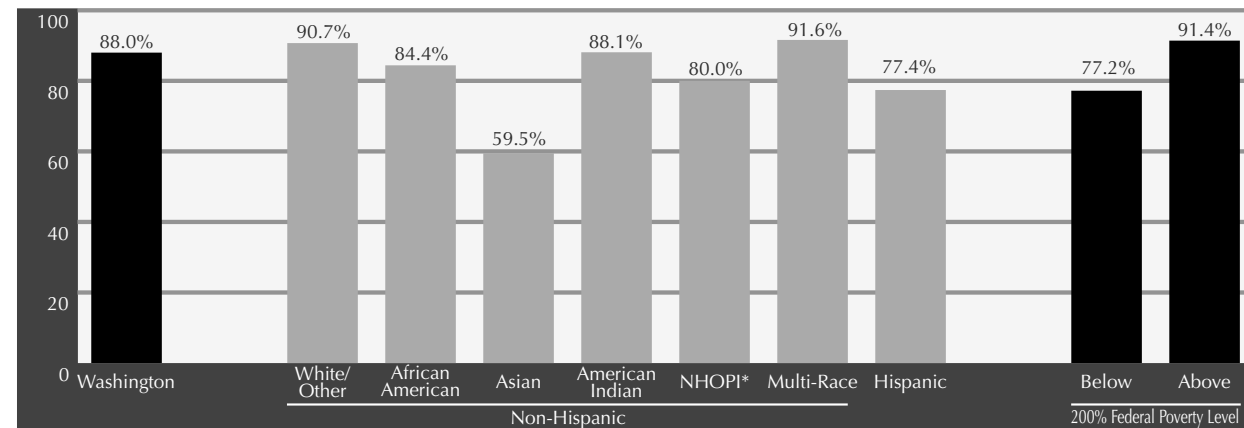
Note: Past 30-Day Use of Alcohol means having had at least one drink of alcohol during the past 30 days.

Asian-Americans, Hispanics, and Lower-Income Individuals Have Lower Rates of Alcohol Use.



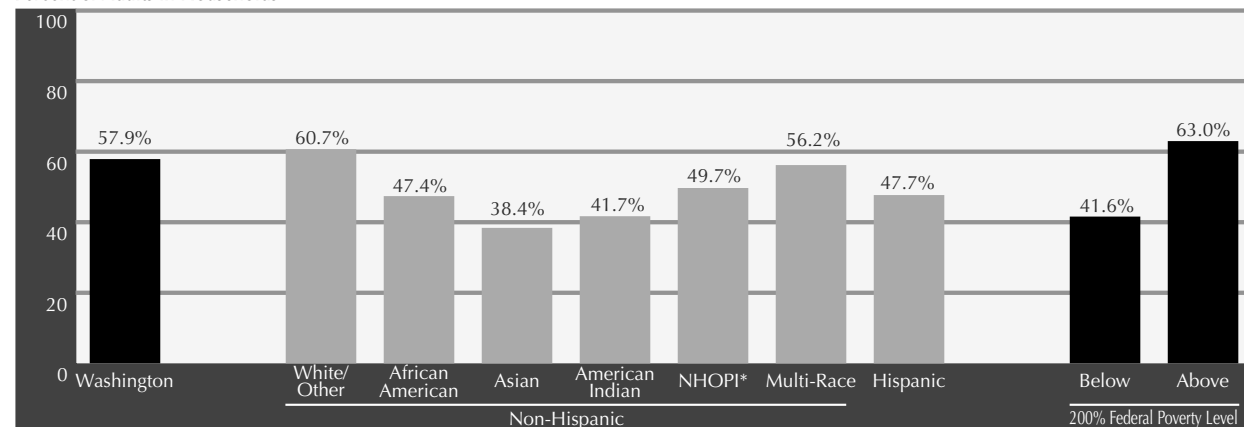
Lifetime Use of Alcohol

Percent of Adults in Households



Past 30-Day Use of Alcohol

Percent of Adults in Households



*Native Hawaiian or Pacific Islander

Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.

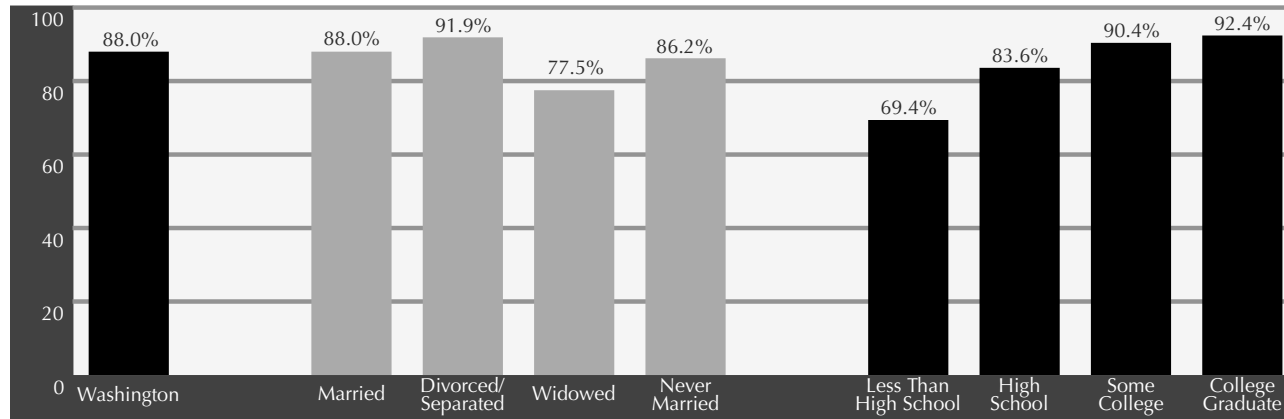
Note: Past 30-Day Use of Alcohol means having had at least one drink of alcohol during the past 30 days.



Widowed Individuals and Those Who Never Completed High School Have Lower Rates of Alcohol Use.

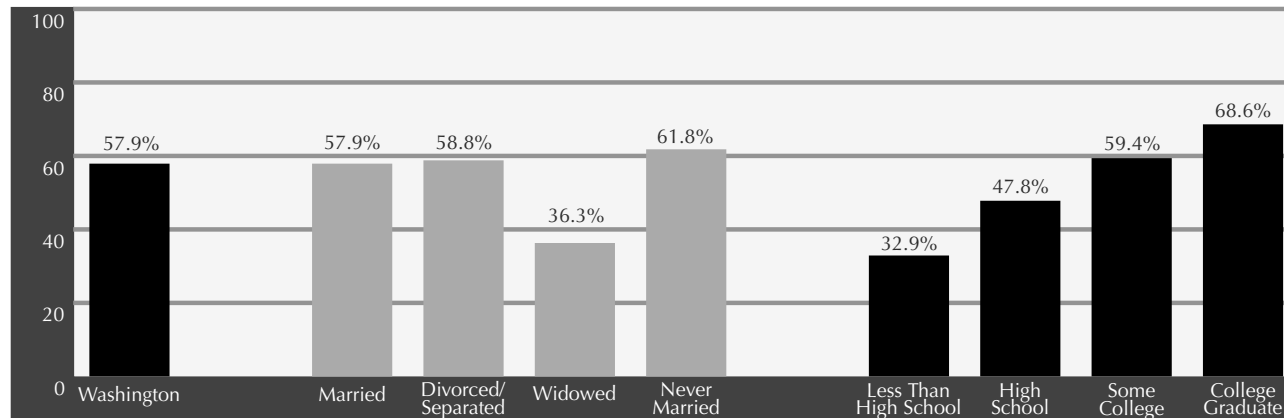
Lifetime Use of Alcohol

Percent of Adults in Households



Past 30-Day Use of Alcohol

Percent of Adults in Households



Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

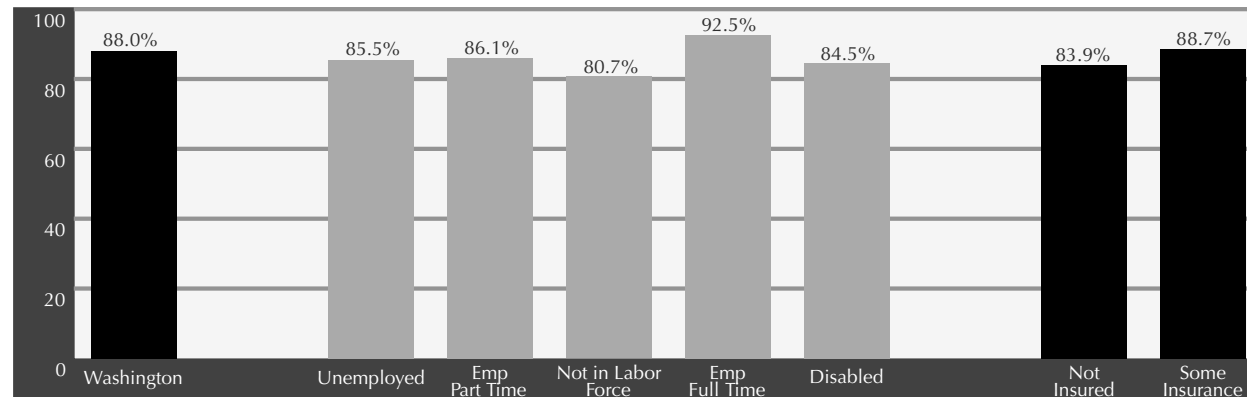
Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.
 Note: Past 30-Day Use of Alcohol means having had at least one drink of alcohol during the past 30 days.

Individuals Not in the Labor Force and Disabled, or Who are Without Health Insurance are Less Likely to Have Used Alcohol in the Past 30 Days.



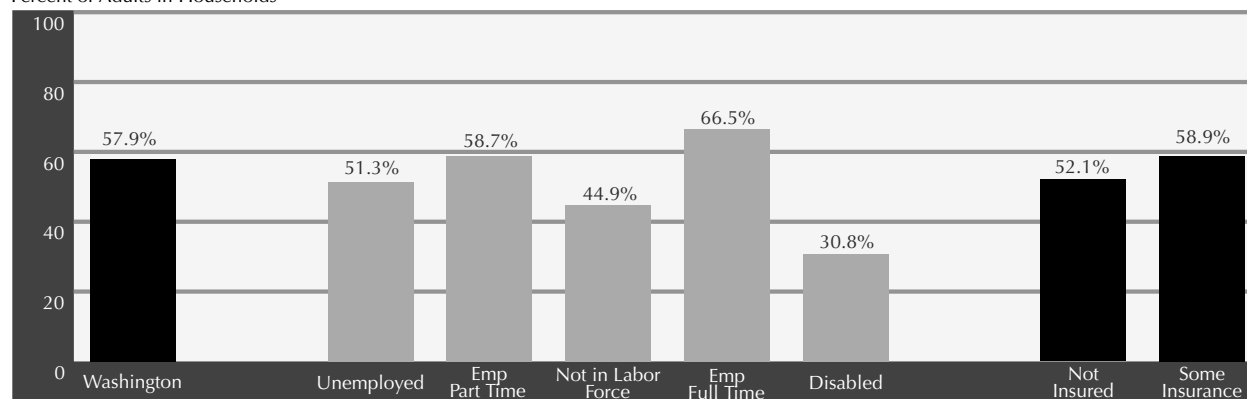
Lifetime Use of Alcohol

Percent of Adults in Households

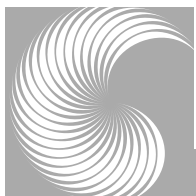


Past 30-Day Use of Alcohol

Percent of Adults in Households



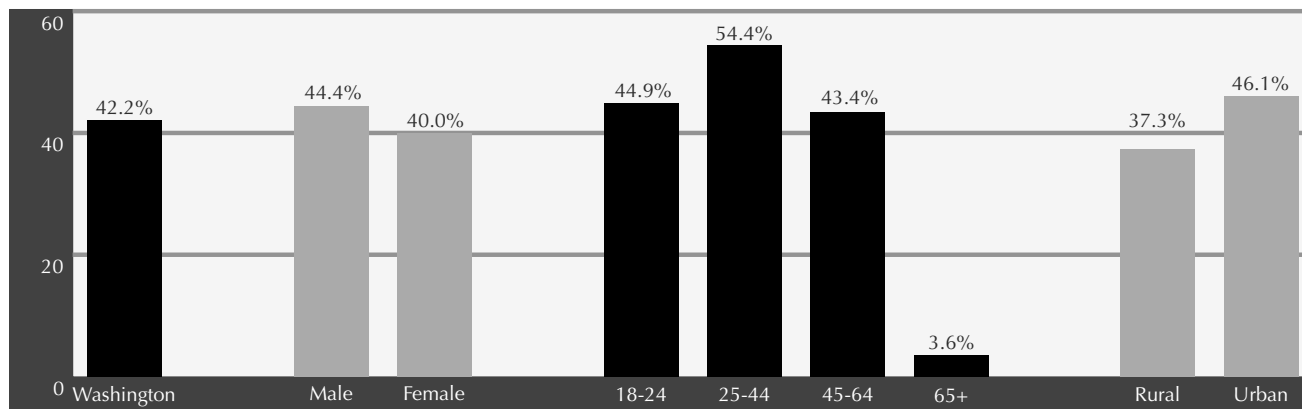
Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.



Individuals Over 65 and Rural Residents Have Lower Rates of Marijuana Use.

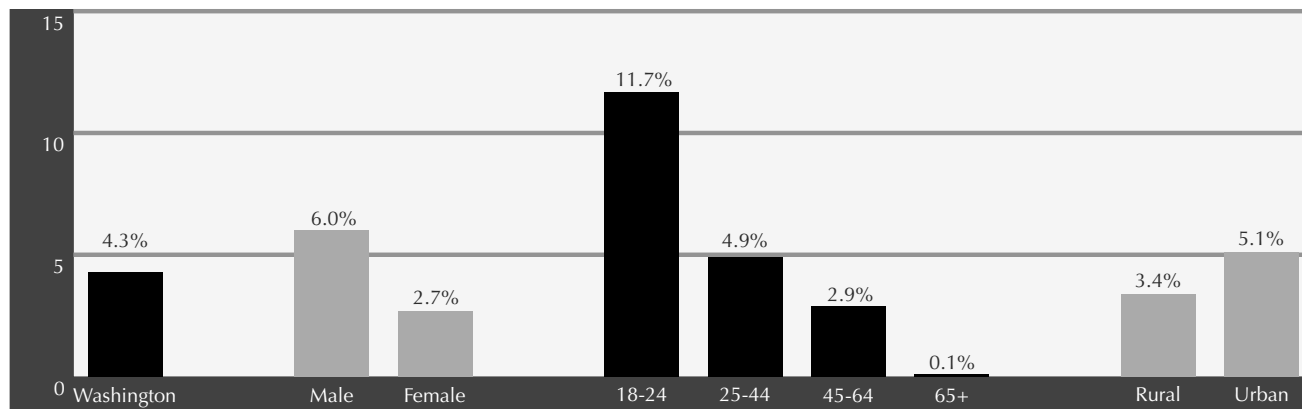
Lifetime Use of Marijuana

Percent of Adults in Households



Past 30-Day Use of Marijuana

Percent of Adults in Households



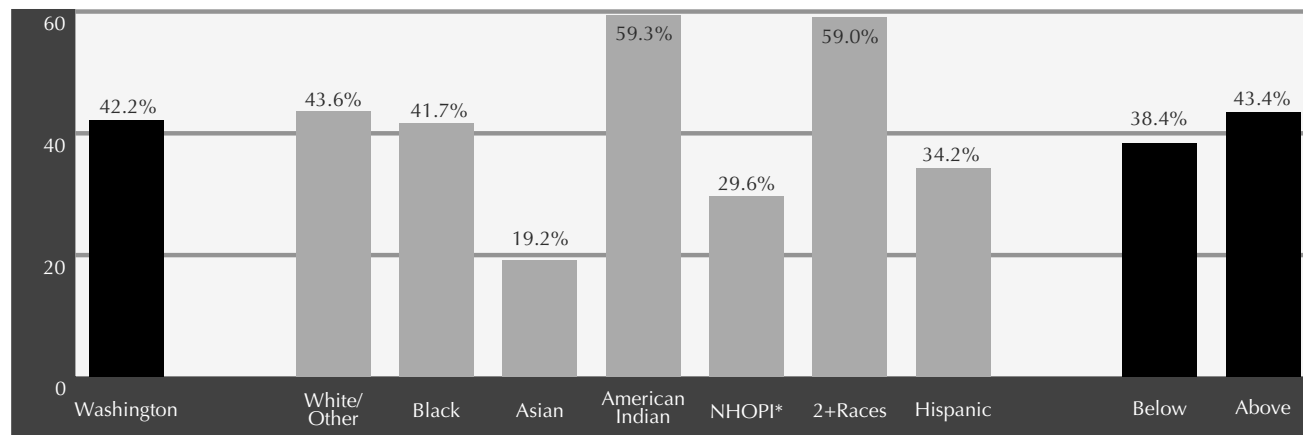
Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

Asian-Americans and Native Hawaiians/ Pacific Islanders Have Lower Rates of Marijuana Use.



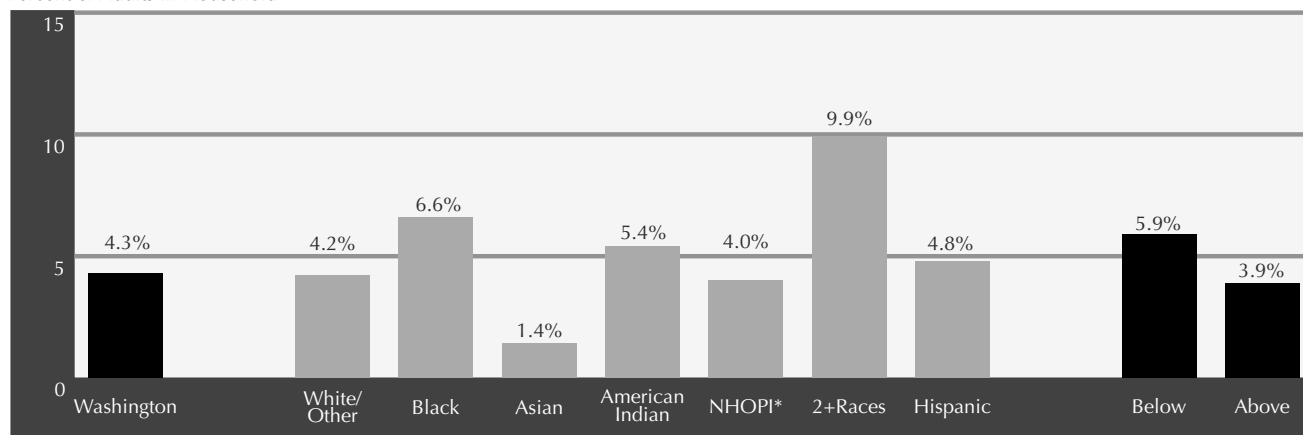
Lifetime Use of Marijuana

Percent of Adults in Household



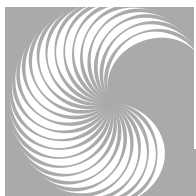
Past 30-Day Use of Marijuana

Percent of Adults in Household



*Native Hawaiian or Pacific Islander

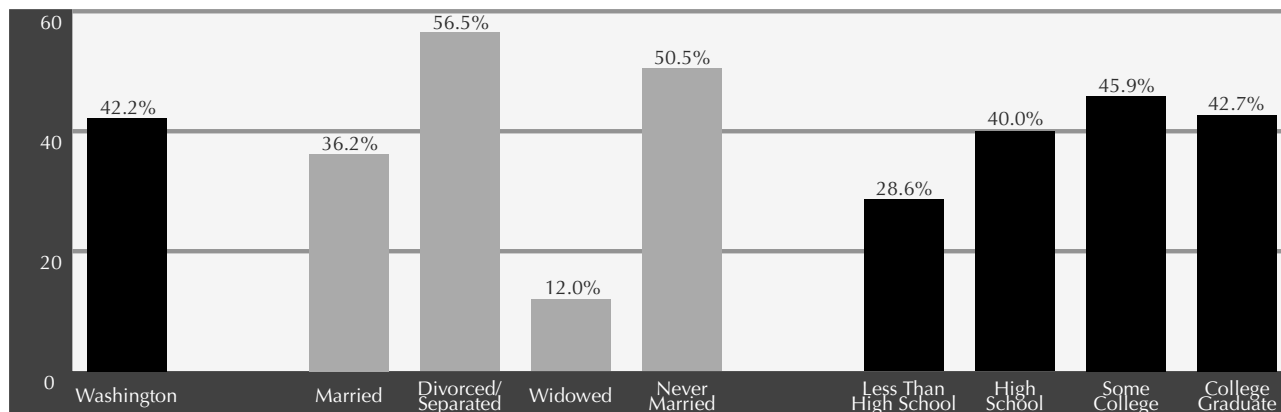
Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.



Widowed Individuals and Those Who Never Completed High School Have Lower Rates of Marijuana Use.

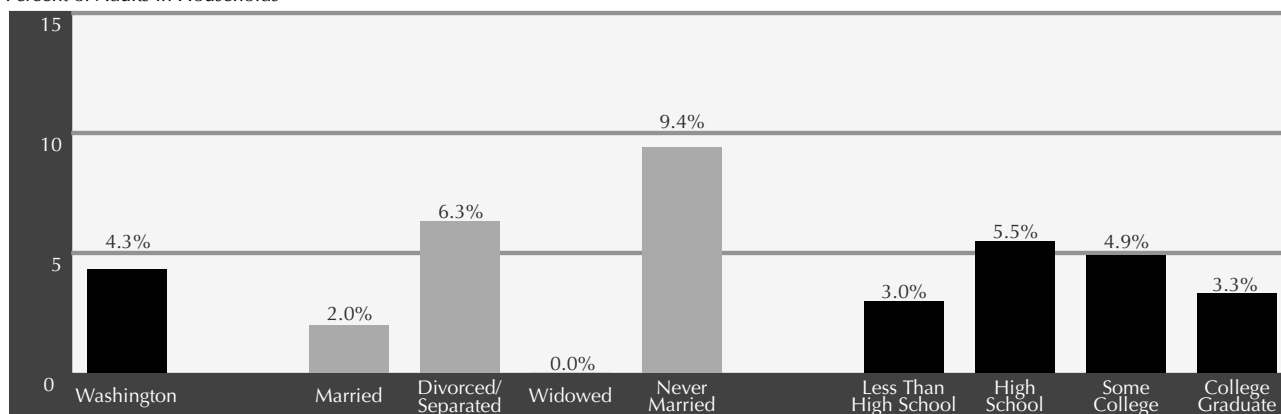
Lifetime Marijuana Use

Percent of Adults in Households



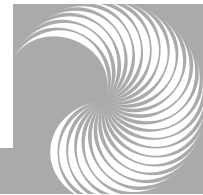
Past 30-Day Use of Marijuana

Percent of Adults in Households



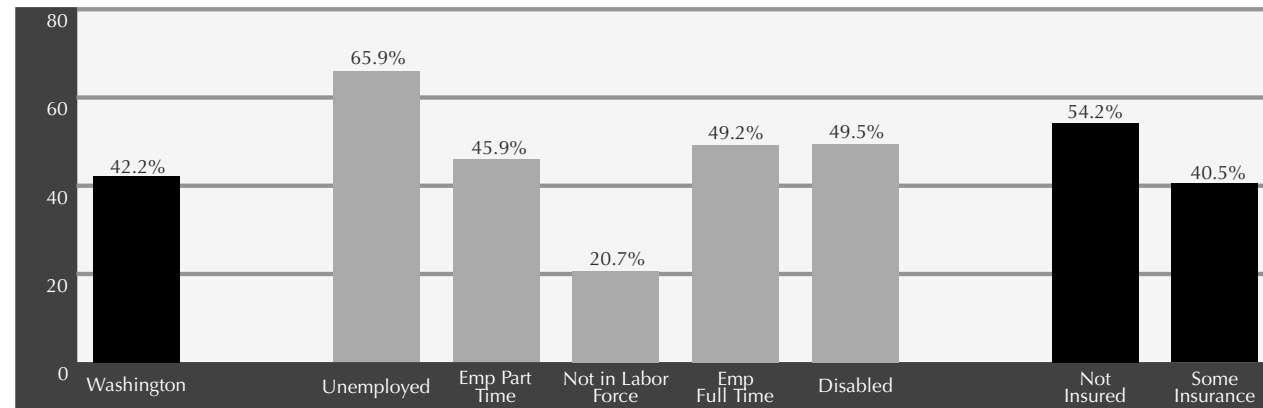
Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

Individuals Not in the Labor Force, and Those With Health Insurance are Less Likely to Have Used Marijuana in the Past 30 Days.



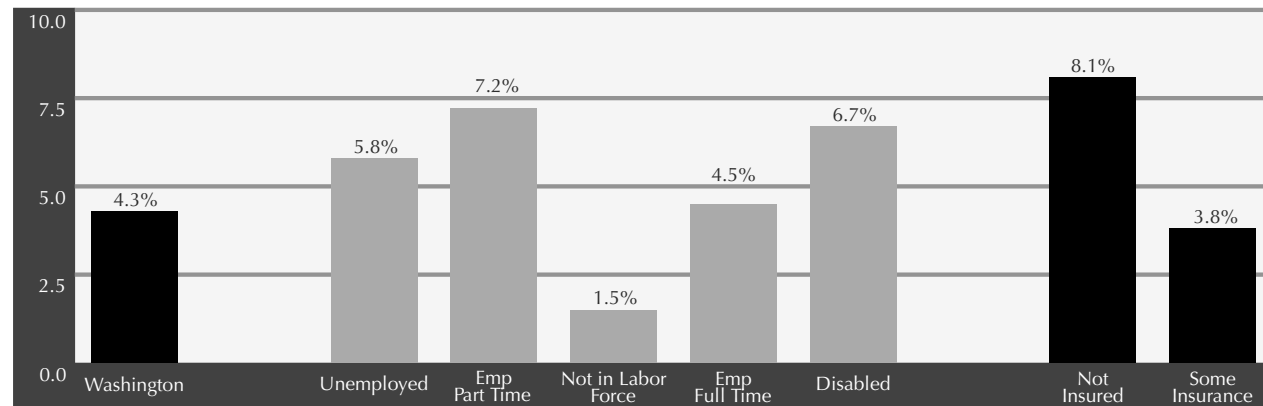
Lifetime Marijuana Use

Percent of Adults in Households

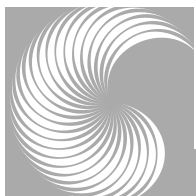


Past 30-Day Use of Marijuana

Percent of Adults in Households



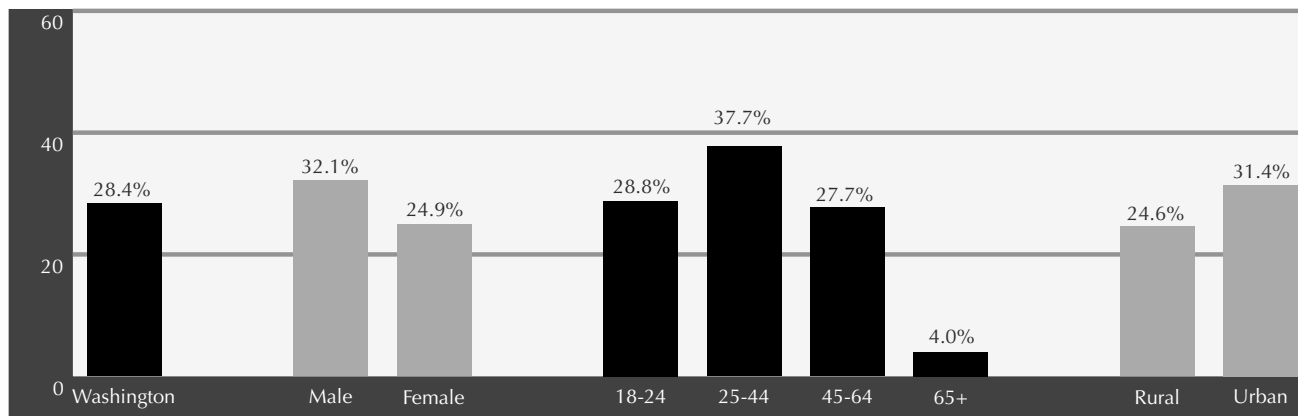
Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.



Individuals Over Age 65 and Rural Residents Have Lower Rates of Use of Illicit Drugs Other than Marijuana.*

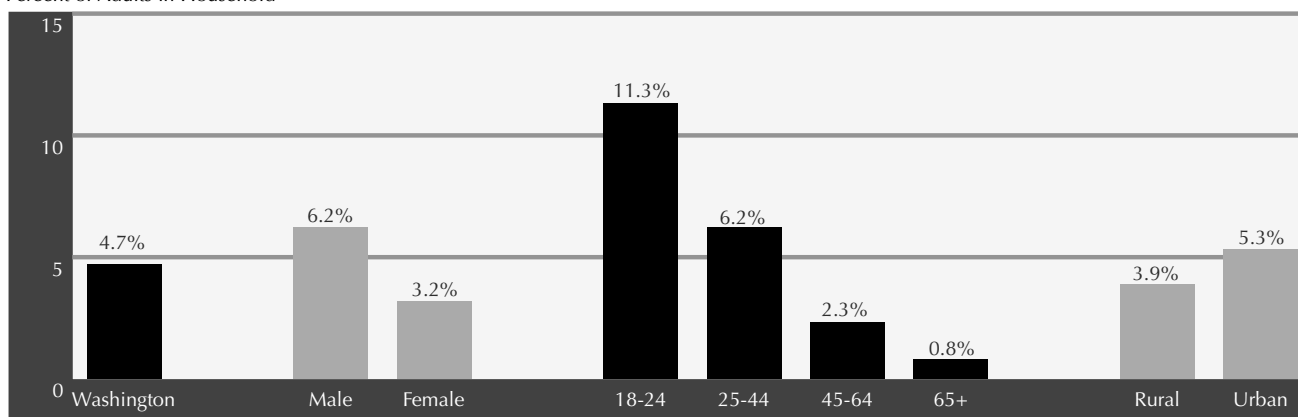
Lifetime Use of Illicit Drugs Other than Marijuana

Percent of Adults in Household



Past 12-Month Use of Illicit Drugs Other than Marijuana

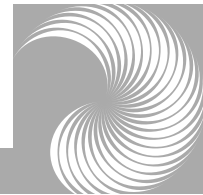
Percent of Adults in Household



Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

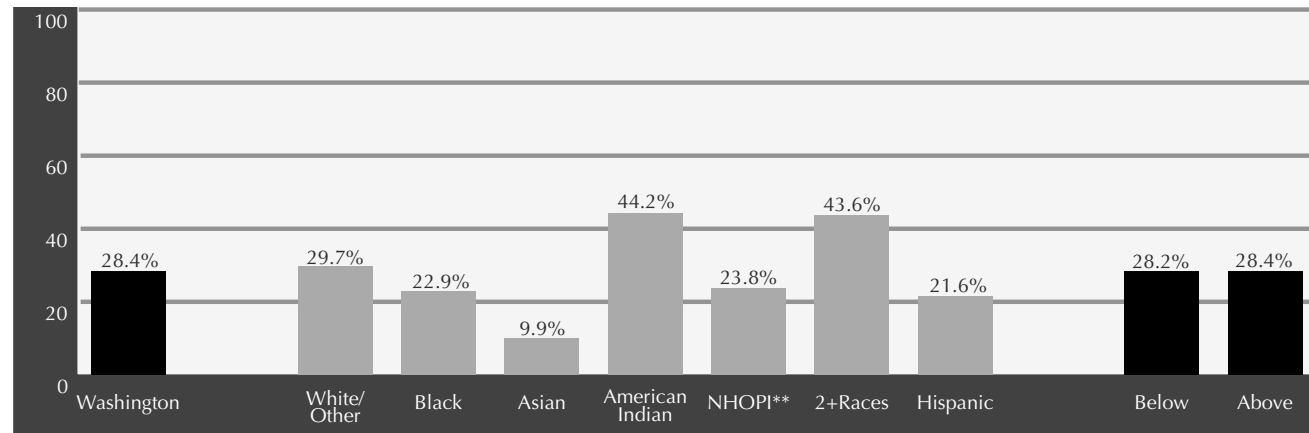
* Illicit drugs other than marijuana include cocaine, stimulants, hallucinogens, heroin, opiates, tranquilizers, sedatives, and inhalants.

American Indians and Multi-Race Individuals Have Higher Rates of Use of Illicit Drugs Other than Marijuana.*



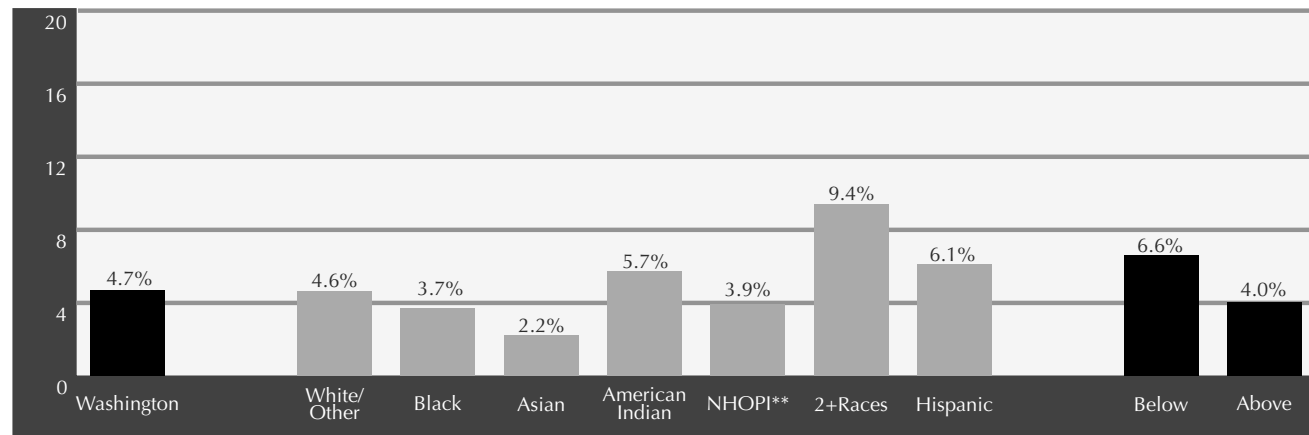
Lifetime Use of Illicit Drugs Other than Marijuana

Percent of Adults in Household



Past 12-Month Use of Illicit Drugs Other than Marijuana

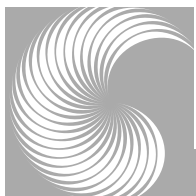
Percent of Adults in Household



**Native Hawaiian or Pacific Islander

Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

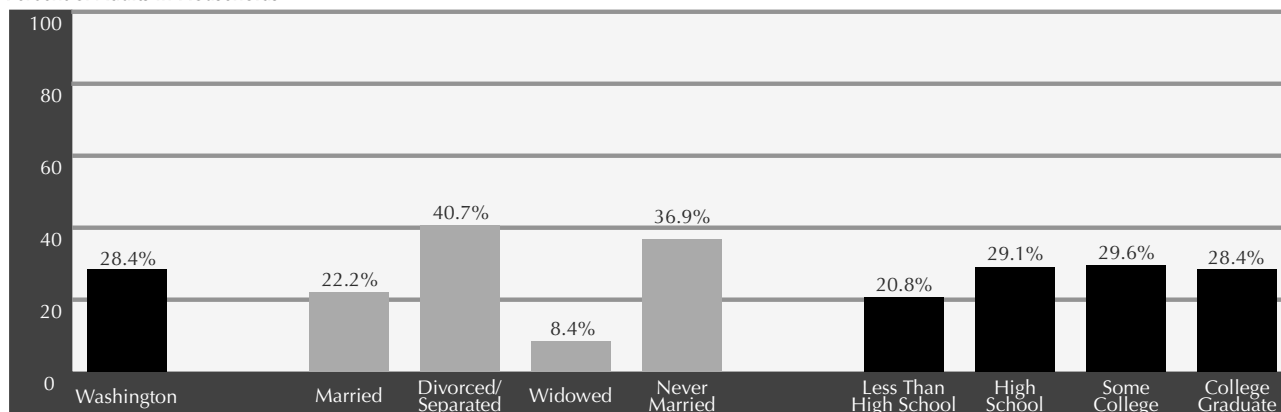
* Illicit drugs other than marijuana include cocaine, stimulants, hallucinogens, heroin, opiates, tranquilizers, sedatives, and inhalants.



Widowed Individuals and Those Who Never Graduated from High School Have Lower Rates of Use of Illicit Drugs Other than Marijuana.*

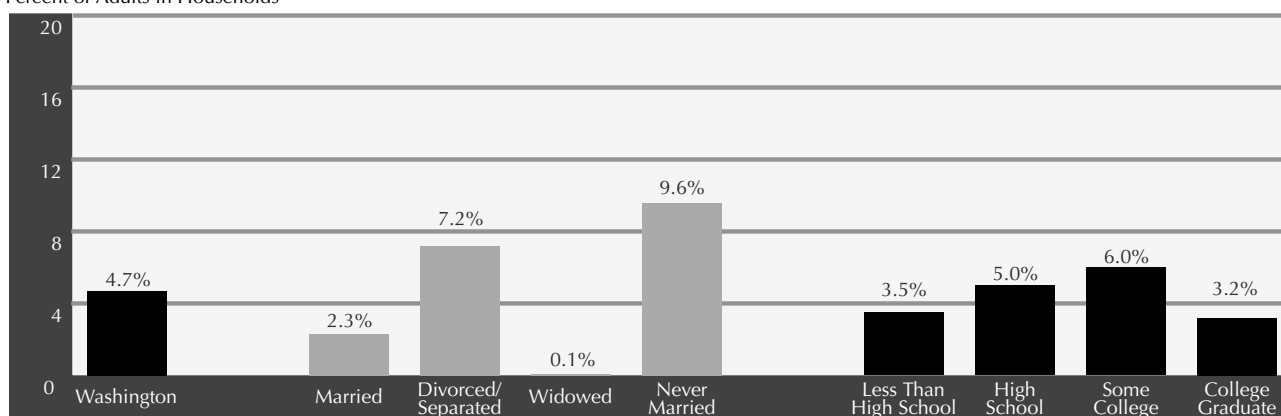
Lifetime Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households



Past 12-Month Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households



Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

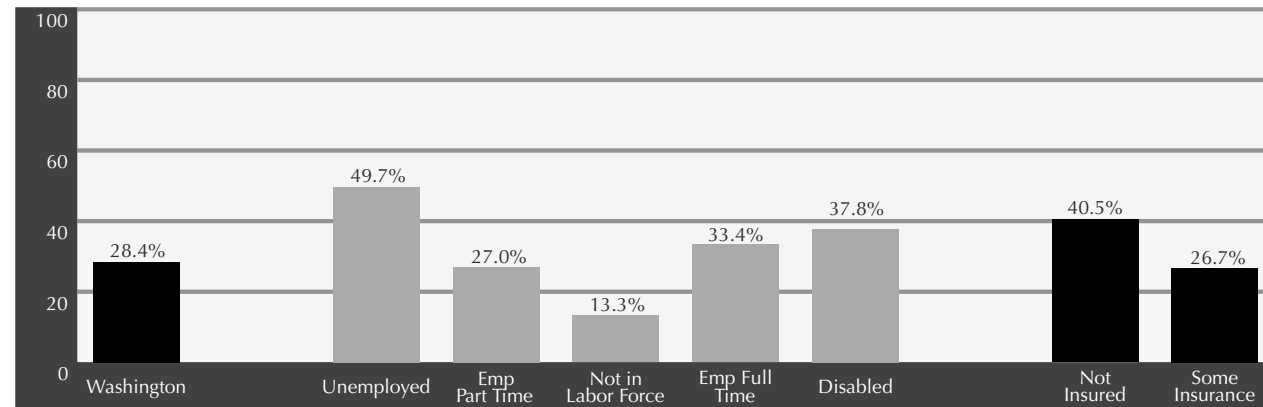
* Illicit drugs other than marijuana include cocaine, stimulants, hallucinogens, heroin, opiates, tranquilizers, sedatives, and inhalants.

Individuals Who are Unemployed, Disabled, and Lack Health Have Higher Rates of Use of Illicit Drugs Other than Marijuana.*



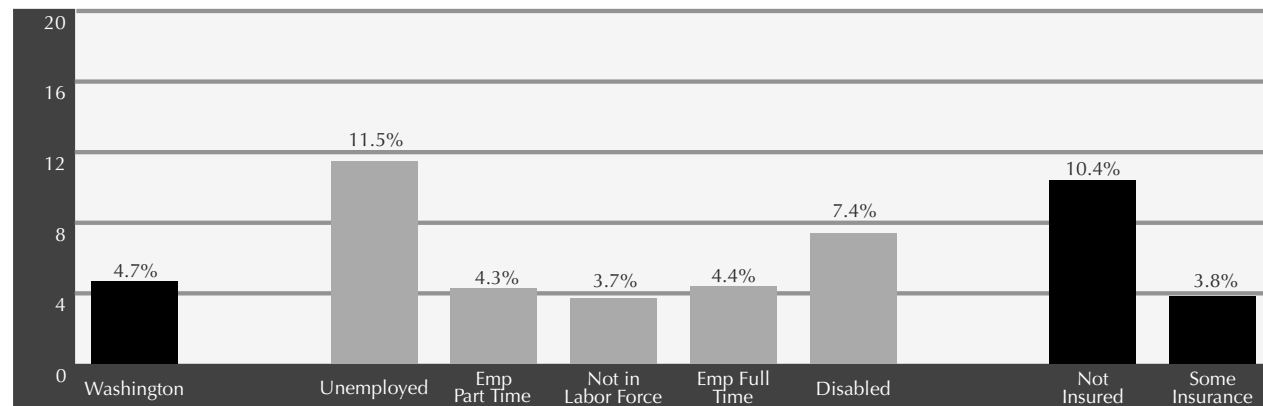
Lifetime Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households



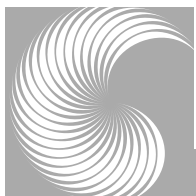
Past 12-Months Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households

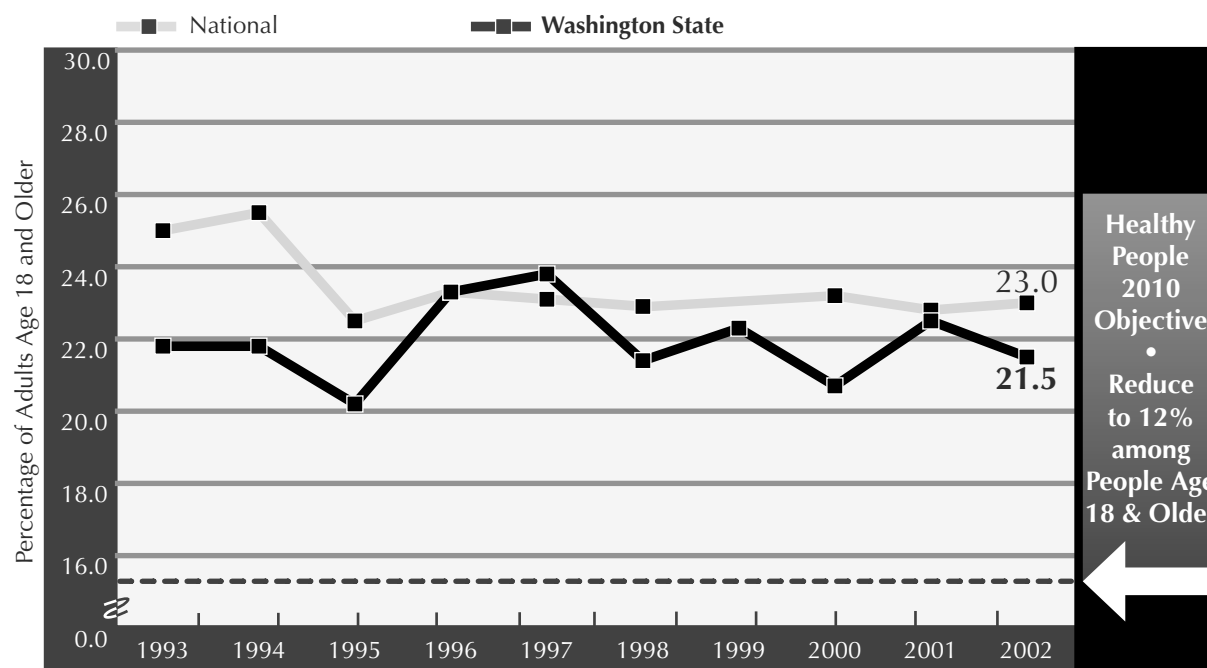


Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

* Illicit drugs other than marijuana include cocaine, stimulants, hallucinogens, heroin, opiates, tranquilizers, sedatives, and inhalants.



Smoking Prevalence Among Adults in Washington State Remains Virtually Unchanged from a Decade Ago.



Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

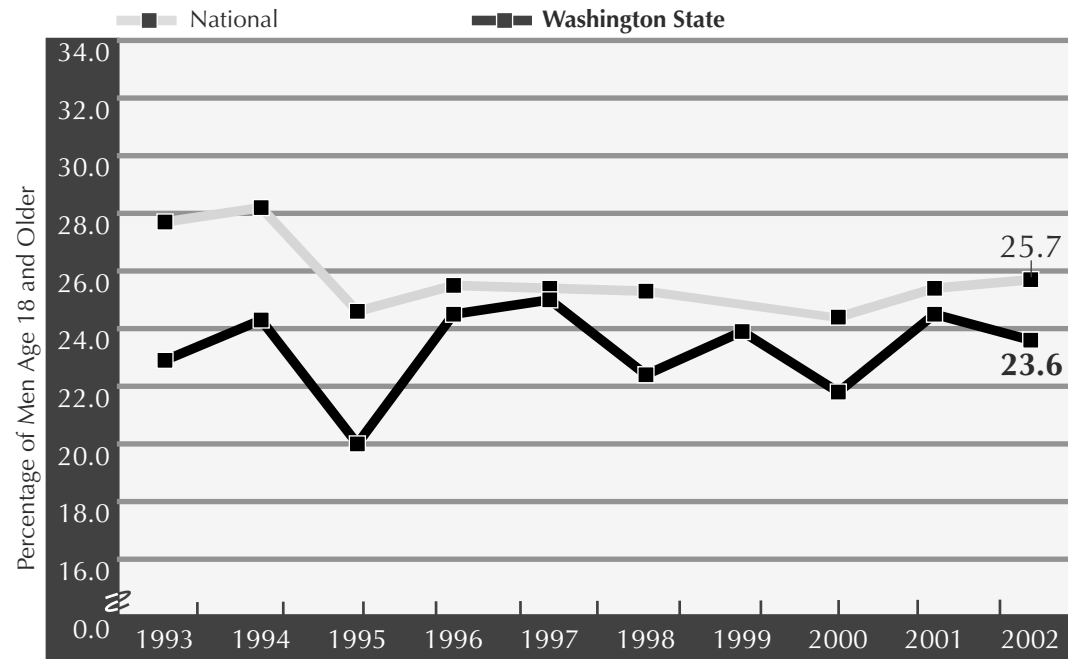
Cigarette smoking in the United States causes serious illnesses among an estimated 8.6 million Americans annually, with \$157 billion in health-related economic costs.¹ Tobacco use causes approximately 440,000 deaths each year, and since the 1964 release of the Surgeon General's Report on Smoking and Health, more than ten million Americans have died from smoking-related diseases, including heart disease, lung cancer, emphysema, and other respiratory diseases.²

Smoking rates in the United States and Washington State remain little changed from a decade ago. Despite substantial investments in tobacco prevention activities among teenagers over the past decade, smoking rates among 18-34 year olds in the United States (28.4%) and Washington (26.0%), those most exposed to these activities, are at or close to their highest points in a decade.

¹ Centers for Disease Control and Prevention, "Cigarette Smoking-Attributable Morbidity—United States, 2000," *Morbidity and Mortality Weekly Report* 2003 (52); "Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Economic Costs—United States, 1995-1999," *Morbidity and Mortality Weekly Report* 2002 (51).

² Centers for Disease Control and Prevention, "Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Economic Costs—United States, 1995-1999," *Morbidity and Mortality Weekly Report* 2002 (51); U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta, GA: 2000.

Smoking Prevalence Among Men in Washington State is Virtually Unchanged from a Decade Ago.



Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

Smoking is closely associated with heart disease, cancer, emphysema, and other respiratory diseases. Since the release of the first Surgeon General's report on smoking and health in 1964, more than ten million Americans have died from smoking-related diseases.¹

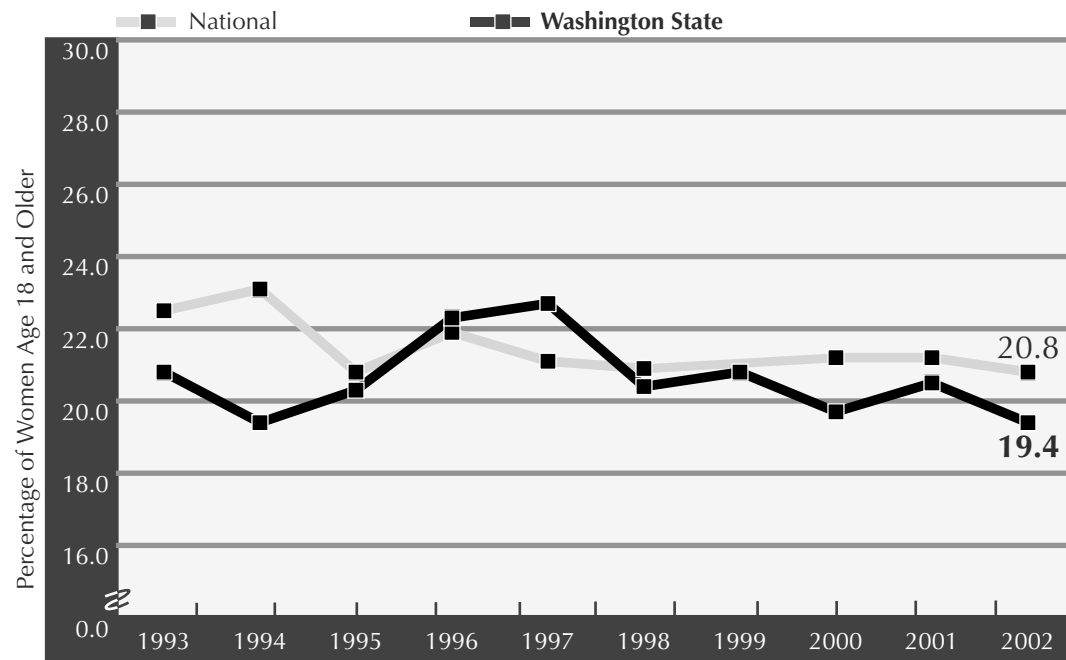
This graph indicates that smoking prevalence among Washington men is slightly lower than among men nationally, and is little changed since 1993. In 2002, some 52.7% of Washington residents who smoked daily tried to quit.² The Division of Alcohol and Substance Abuse is engaged in a new initiative to integrate tobacco cessation into substance abuse treatment activities.

¹ U.S. Department of Health and Human Services, *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta, GA: 2000.

² Centers for Disease Control and Prevention, "State-Specific Prevalence of Current Cigarette Smoking Among Adults—United States, 2002," *Morbidity and Mortality Weekly Report* 2004 (52).



Smoking Prevalence Among Women in Washington State is Little Changed from a Decade Ago.



Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

Besides being linked with heart disease, cancer, emphysema, and other respiratory diseases¹, evidence is accumulating that maternal tobacco use is associated with mental retardation and birth defects such as oral clefts², and with Sudden Infant Death Syndrome.³ More than ten million Americans have died from smoking-related diseases since the Surgeon General released the first report on smoking and health in 1964.⁴

This graph indicates that smoking prevalence among Washington women is slightly lower than among women nationally, and is little changed since 1993. The Division of Alcohol and Substance Abuse is engaged in a new initiative to integrate tobacco cessation into substance abuse treatment activities.

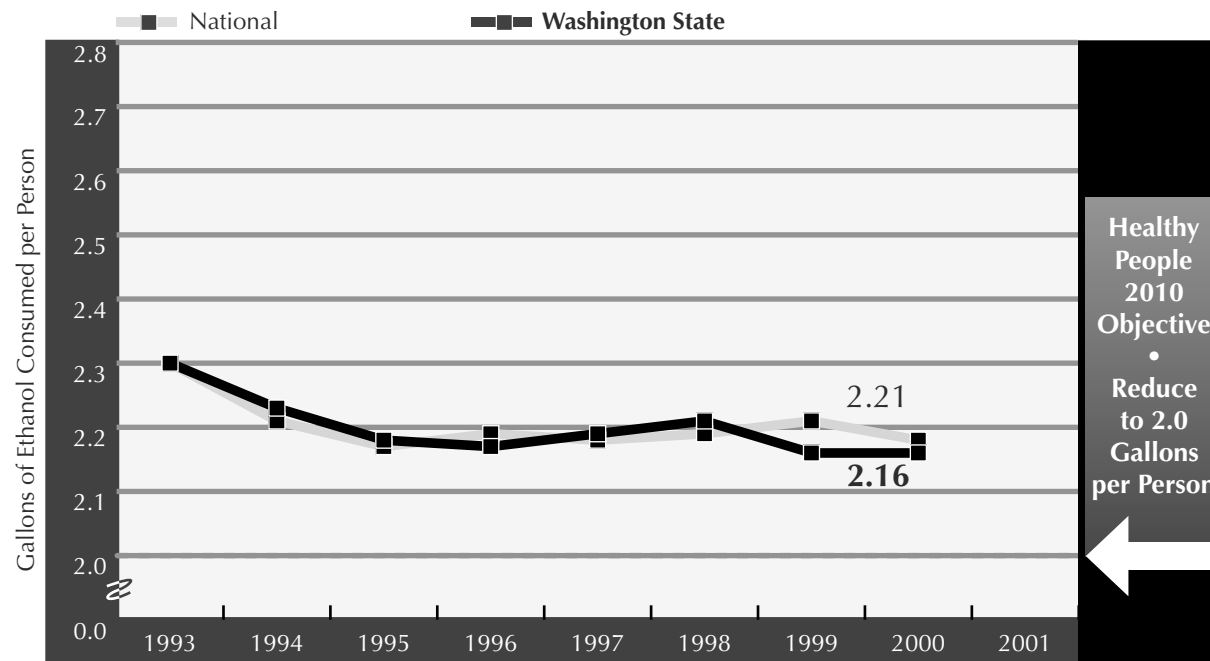
¹ U.S. Department of Health and Human Services, *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta, GA: 2000.

² U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 27-3. Washington, DC: 2000.

³ Klonoff-Cohen, H. et al., "Effect of Passive Smoking and Tobacco Exposure Through Breast Milk on Sudden Infant Death Syndrome," *Journal of the American Medical Association*, March 8, 1995.

⁴ *Reducing Tobacco Use*, op. cit.

Per Capita Alcohol Consumption in Washington State is Similar to That of the Rest of the Nation.



Source: National Institute on Alcohol Abuse and Alcoholism, *Apparent Per Capita Alcohol Consumption: National, State, and Regional Trends, 1977-2000*.

State and national per capita consumption of alcohol (for all persons over age 14) has remained constant over the past seven years, after falling for more than a decade. Per capita consumption is approaching the *Healthy People 2010* target objective. However, in 2002, almost one in five Washington 8th graders reported having used alcohol in the past 30 days¹, binge drinking is on the rise, and chronic drinking rates among adults are at their highest point in a decade.

¹ Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors—2002*. Olympia, WA: 2003.



Adult Binge Drinking is on the Rise Both Nationally and in Washington State.



Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

Binge drinking (defined as having five or more alcoholic drinks at one occasion, one or more times in the past month) is a particularly dangerous form of alcohol consumption, and is associated with traffic fatalities, accidents, drownings, emergency department admissions, and alcoholism. Binge drinking rates among college students (44% in 2001) are more than twice the rate for all adults¹, and is associated with increased incidence of unplanned and unprotected sex, alcohol-related sexual assaults, and date rape.²

After falling substantially for the previous decade, binge drinking in Washington State has been rising since 1995.

¹ Wechsler, H. et al., "Trends in College Binge Drinking During a Period of Increased Prevention Efforts: Findings from Four Harvard School of Public Health Study Surveys, 1993-2001," *Journal of American College Health* 50(5), 2002.

² Taskforce on College Drinking, National Advisory Council on Alcohol Abuse and Alcoholism, *A Call to Action: Changing the Culture of Drinking at U.S. Colleges*. Bethesda, MD: U.S. Department of Health and Human Services, National Institute on Alcohol Abuse and Alcoholism, 2002.

Chronic Drinking Rates Among Washington State Adults are at Their Highest Point in More than a Decade.



Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

Chronic drinking (defined as having had an average of two or more drinks per day per month) is associated with alcohol-related problems, as it may impair mental performance and physical coordination. It may also lead to alcohol dependency.¹

Chronic drinking among Washington State adults appears to be on the rise, is at its highest point in more than a decade, and is 83.8% higher than in 1993.

The Problem: Substance Abuse Prevalence & Trends

AREAS OF
SUBSTANCE
ABUSE
IMPACT

Birth Defects/
Complications

Accident
Risks

Health
Consequences

Infectious
Diseases

Crime

Violence

Family
Distress

The Problem: Substance Abuse Prevalence & Trends

**AREAS OF
SUBSTANCE
ABUSE
IMPACT**

**Birth Defects/
Complications**

**Accident
Risks**

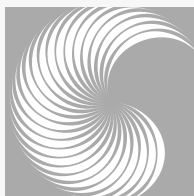
**Health
Consequences**

**Infectious
Diseases**

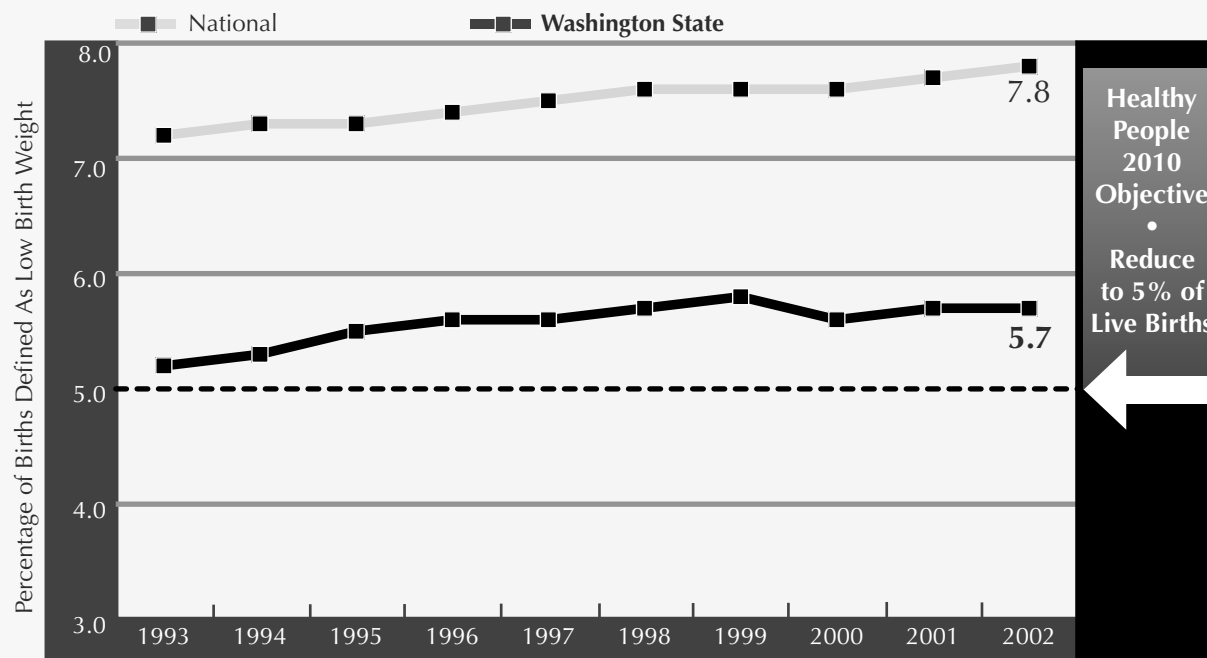
Crime

Violence

**Family
Distress**



A Lower Percentage of Low Birth Weight Babies are Born in Washington State than Nationally.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Smoking is associated with 20-30% of all low birth weight (LBW) births, as well as being the risk factor most closely associated with neonatal deaths.¹

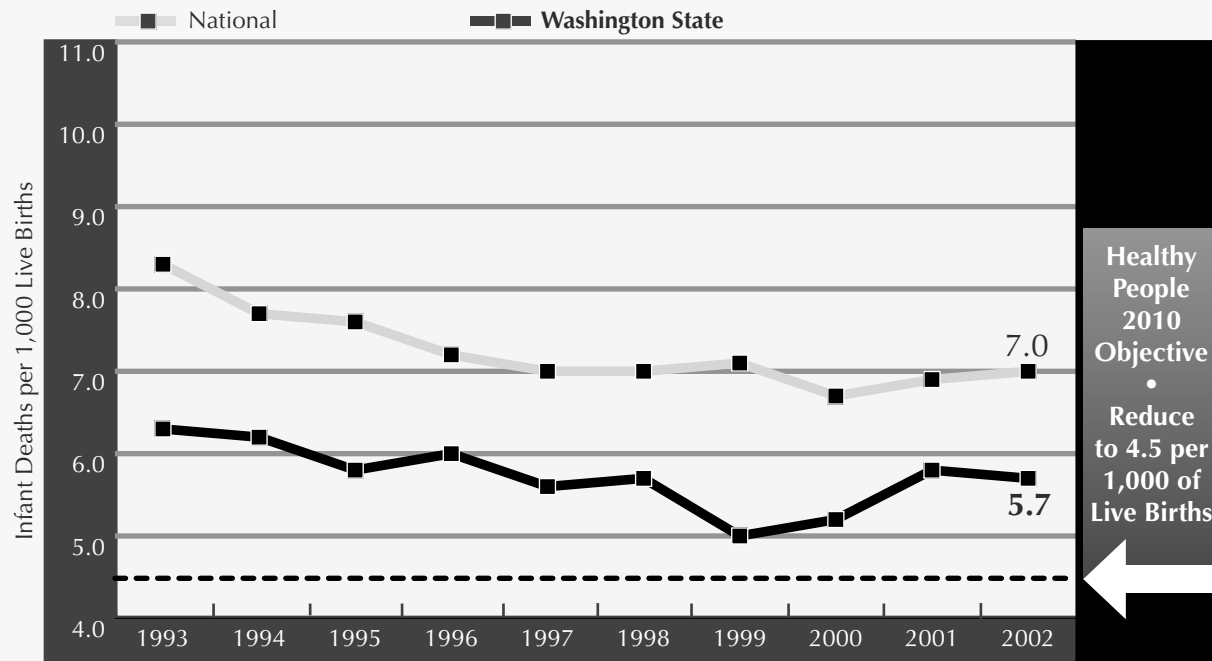
LBW infants are newborns weighing less than 2,500 grams (5 pounds, 8 ounces) and include those born prematurely and those whose intrauterine growth is retarded. LBW is associated with long-term disabilities, including cerebral palsy, autism, mental retardation, hearing impairments, and other developmental problems.² Two Washington studies reported fewer LBW births among substance-abusing women who received chemical dependency treatment during pregnancy.³

¹ U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 16-4; 16-34. Washington, DC, 2000.

² Ibid.

³ Krohn, M., "Preliminary Findings for MOMS Project", *Focus*, 1993. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse. Shrager, L., Kenny F., and Cathon, L., *Substance Abuse Treatment for Female DASA Clients: Treatments, Birth Outcomes, and Demographic Profiles*. Olympia, WA: Washington State Department of Social and Health Services, Office of Research and Data Analysis, 1993.

Washington State Has a Lower Infant Death Rate than the Nation.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

There is a clear association between overall rates of alcohol use during pregnancy and infant death rates. Infant mortality rates for children born to mothers on Medicaid in Washington State and identified as substance abusers are more than twice as high as those for infants born to mothers on Medicaid not so identified.¹

Infant death rates represent the number of infants per thousand live births who die within their first year of life. Sudden Infant Death Syndrome (SIDS) accounts for nearly one-third of all infant deaths after the first month of life.² SIDS has been linked with passive smoking in the infant's environment and maternal smoking during the time period of breastfeeding.³

Washington State has had consistently lower infant death rates than the nation. Rates have been dropping for the past 15 years. Advances in medical technology, coupled with public education campaigns to ensure infants are put to sleep on their backs to lower SIDS risk, are primarily responsible for the downward trend.

¹ First Steps Database, 1990-1997. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, 1999.

² U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 16-1. Washington, DC, 2000.

³ Klonoff-Cohen, H. et al., "Effect of Passive Smoking and Tobacco Exposure Through Breast Milk on Sudden Infant Death Syndrome," *Journal of the American Medical Association*, March 8, 1995.

The Problem: Substance Abuse Prevalence & Trends

**AREAS OF
SUBSTANCE
ABUSE
IMPACT**

Birth Defects/
Complications

Accident
Risks

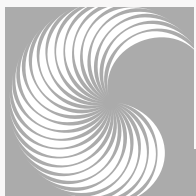
Health
Consequences

Infectious
Diseases

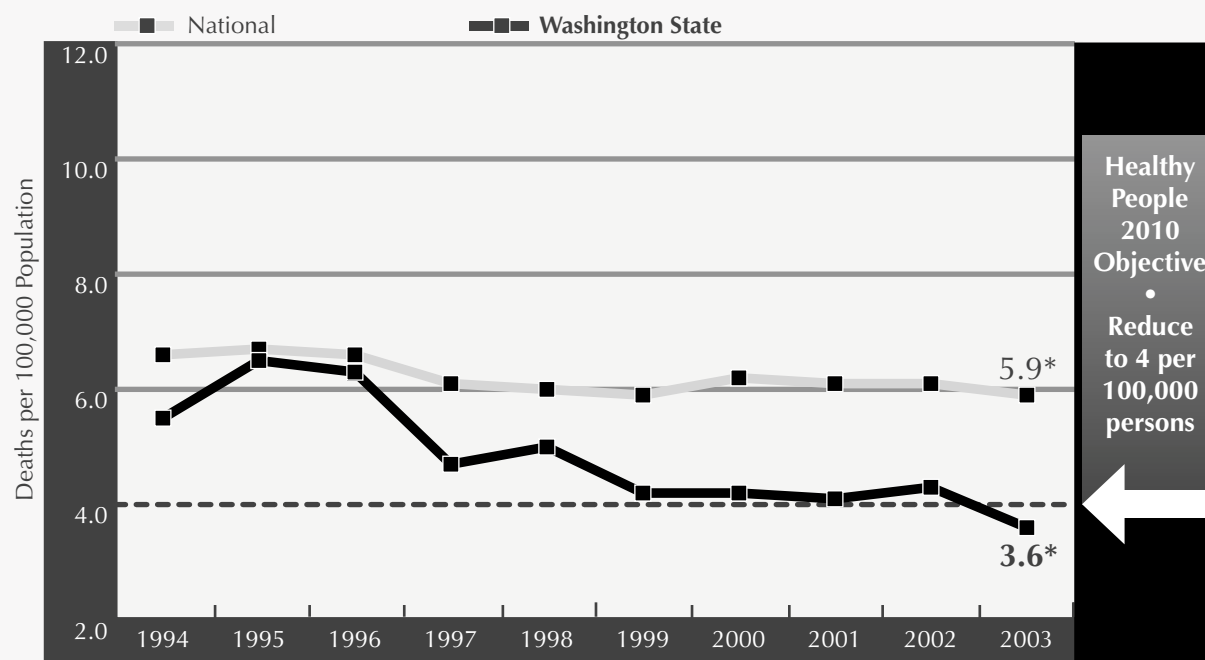
Crime

Violence

Family
Distress



Driving-Under-the-Influence (DUI) Statutes Implemented in 1999 in Washington State are Closely Associated with Lower Alcohol-Related Motor Vehicle Fatality Rates.



*2003 data is preliminary

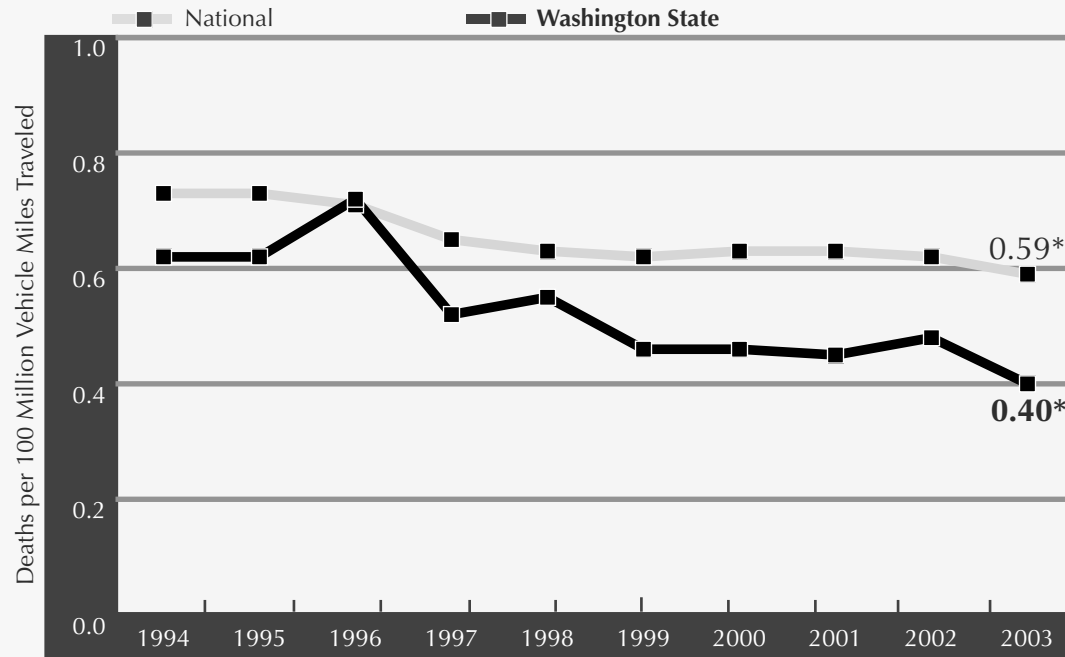
Source: National data from the National Center for Statistics & Analysis, National Highway Traffic Safety Administration. State data from the Fatality Analysis Reporting System, Washington Traffic Safety Commission.

Enhancements to Washington State's Driving-Under-the-Influence (DUI) statutes, including a lowering of the blood-alcohol concentration (BAC) for a DUI determination from .10% BAC to .08% BAC, went into effect in 1999. Since then, the rate of alcohol-related motor vehicle fatalities has dropped substantially. Similar changes have been demonstrated nationwide. The alcohol-related fatality rate for youth is higher than for adults, but nationwide has dropped more than 50% since 1982, mostly as a result of enforcement of minimum drinking age laws.¹

The number of alcohol-related fatalities in Washington State has declined from 296 in 1994 to 221 in 2003, representing a drop of 25.3%.

¹ U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 26-14. Washington, DC. 2000.

The Death Rate from Alcohol-Related Motor Vehicle Crashes per 100 Million Miles Traveled Now Stands at All-Time Lows.



*2003 data is preliminary

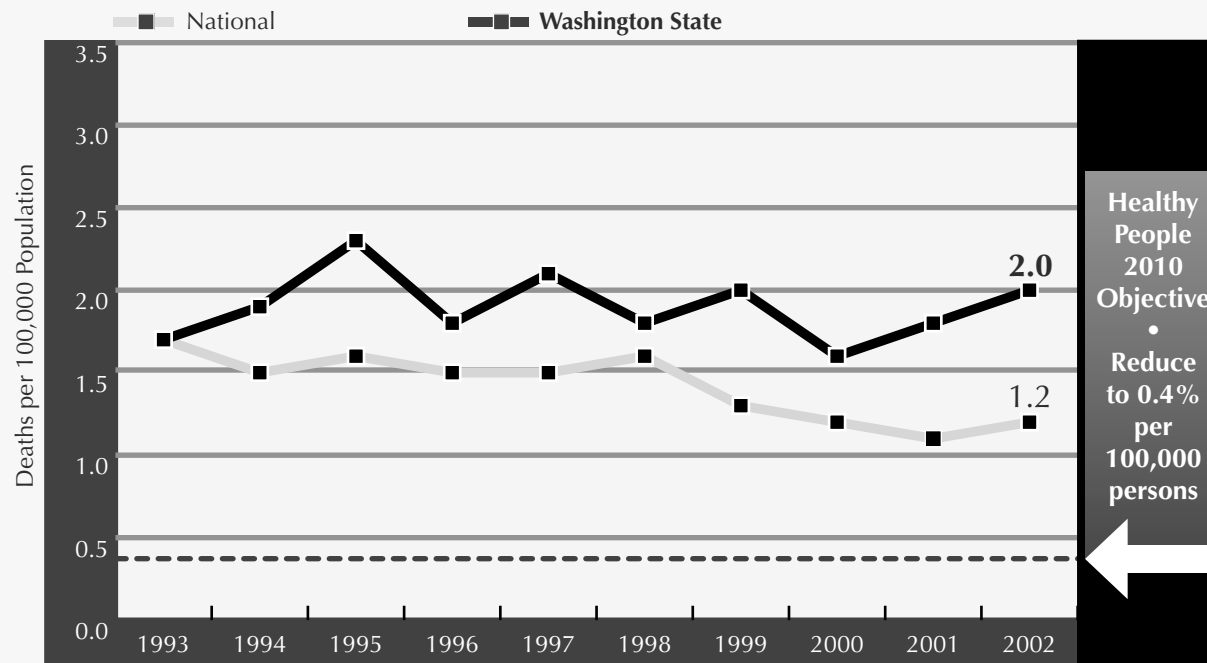
Source: National data from the National Center for Statistics & Analysis, National Highway Traffic Safety Administration. State data from the Fatality Analysis Reporting System, Washington Traffic Safety Commission.

In 2003, the motor vehicle fatality rate per 100,000 vehicle miles driven reached historic lows, both nationally and in Washington State. Lower fatalities are associated with enforcement of minimum drinking age and zero tolerance laws, and statutes setting lower blood alcohol concentration BAC standards for driving-under-the-influence.

Research indicates that the 5% of motorists who do not wear seatbelts account for over 50% of individuals killed in traffic crashes. Unbuckled motorists are more likely to engage in high-risk driving behaviors such as drunk driving and speeding, and are more likely to die when a crash occurs.¹



Washington State Has a Higher Rate of Deaths Due to Drowning than the Nation.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

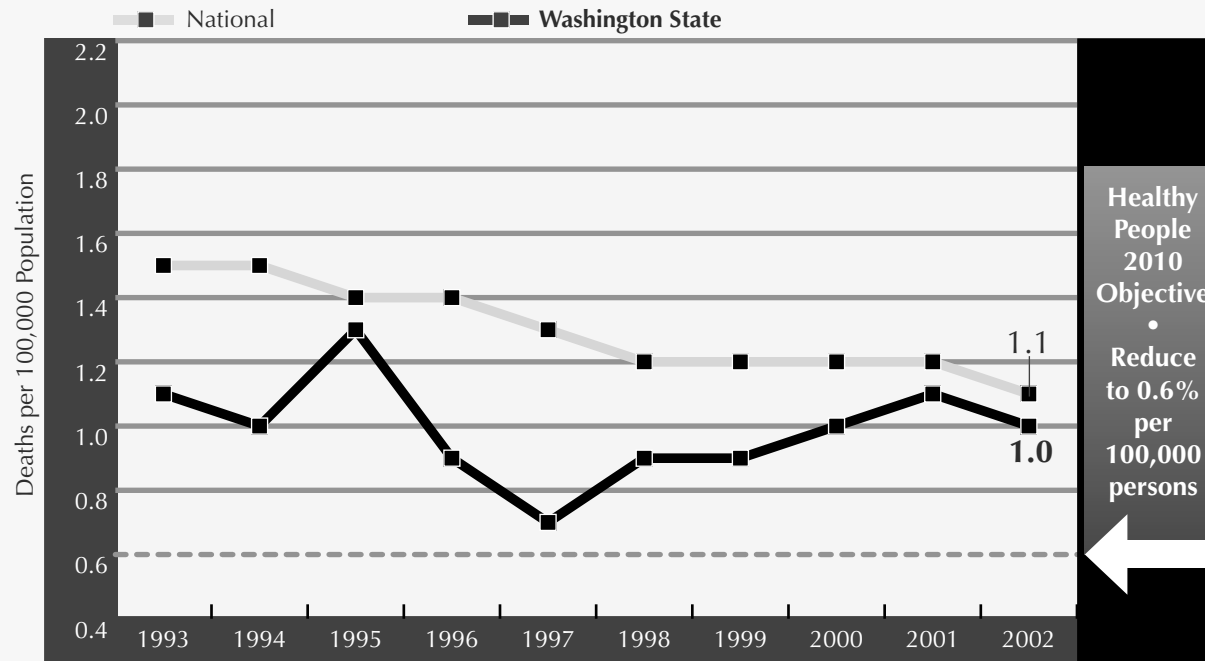
Alcohol is involved in approximately 50% of deaths associated with water recreation.¹

This graph indicates that the rate of drowning deaths in Washington State has been consistently higher than the national rate since 1993. There were 119 drowning deaths in Washington State in 2002, up from 92 in 2000, representing a 29.3% increase. Nationally, drowning is the second leading cause of injury-related deaths for children and youth ages 1-19.²

¹ U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 15-40. Washington, DC: 2000.

² Ibid.

The Rate of Deaths Due to Residential Fires in Washington State Has Been Rising.



Source: National Data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

This graph indicates that the rate of deaths due to residential fires in Washington State has been rising in the past five years. There were 39 such deaths in 1997, and 57 in 2002, representing a 46% increase.

Fires are the second leading cause of unintentional injury death among children. Compared to the total population, children under age four have a fire death rate more than twice the national average. Two-third of fire related death and injuries among children under age five occur in homes without working smoke alarms.¹ Tobacco use is the leading cause of residential fire deaths.² Smoking causes an estimated 30% of U.S. fire deaths; costs related to fires have fallen in association with lower rates of smoking.³

¹ U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 15-35. Washington, DC: 2000.

² Centers for Disease Control and Prevention, *Fire Deaths and Injuries*. Atlanta, GA: 2000.

³ Leistikow, B., et al., "Fire Injuries, Disasters, and Costs from Cigarettes and Cigarette Lights: A Global Overview," *Preventive Medicine* 31:2, 2000.

The Problem: Substance Abuse Prevalence & Trends

**AREAS OF
SUBSTANCE
ABUSE
IMPACT**

Birth Defects/
Complications

Accident
Risks

**Health
Consequences**

Infectious
Diseases

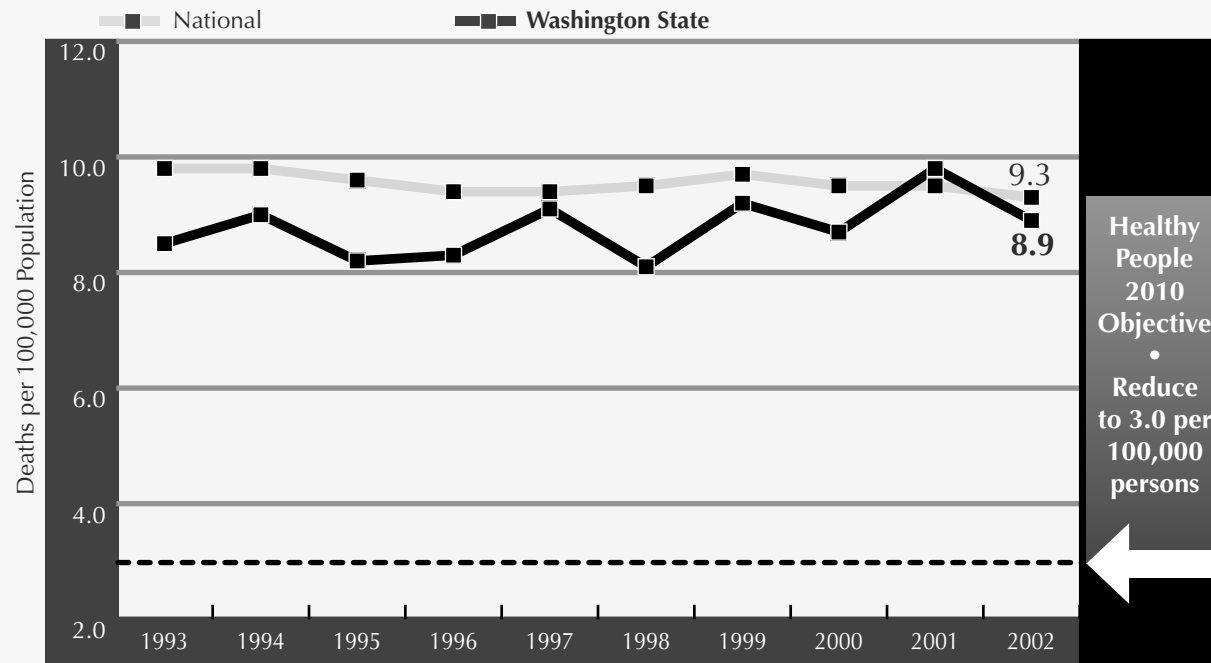
Crime

Violence

Family
Distress



Sustained Alcohol Consumption is the Leading Cause of Chronic Liver Disease and Cirrhosis Deaths.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

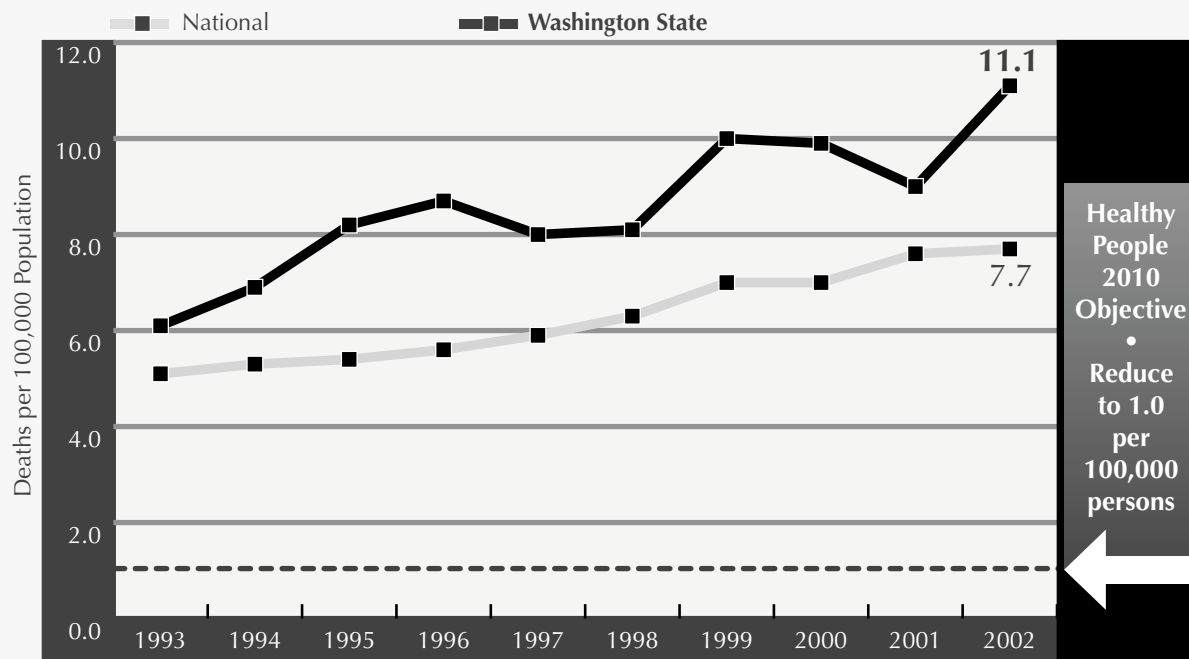
Cirrhosis occurs when healthy liver tissue is replaced with scarred tissue until the liver is unable to function effectively. Sustained heavy alcohol consumption is the leading cause of cirrhosis.¹ Cirrhosis is also associated with hepatitis C and, though less commonly in the United States, hepatitis B², which are often transmitted during intravenous drug use. Once the liver is severely damaged, treatment is often limited to liver transplants.

Little progress has been made in Washington State or nationally in the past decade toward the *Healthy People 2010* target objective.

¹ U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 26-16. Washington, DC: 2000.

² National Digestive Diseases Information Clearinghouse (NDDIC), *Cirrhosis of the Liver*. Bethesda, MD: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, 2003.

The Drug-Induced Death Rate in Washington State is Almost Double What It was in 1993.



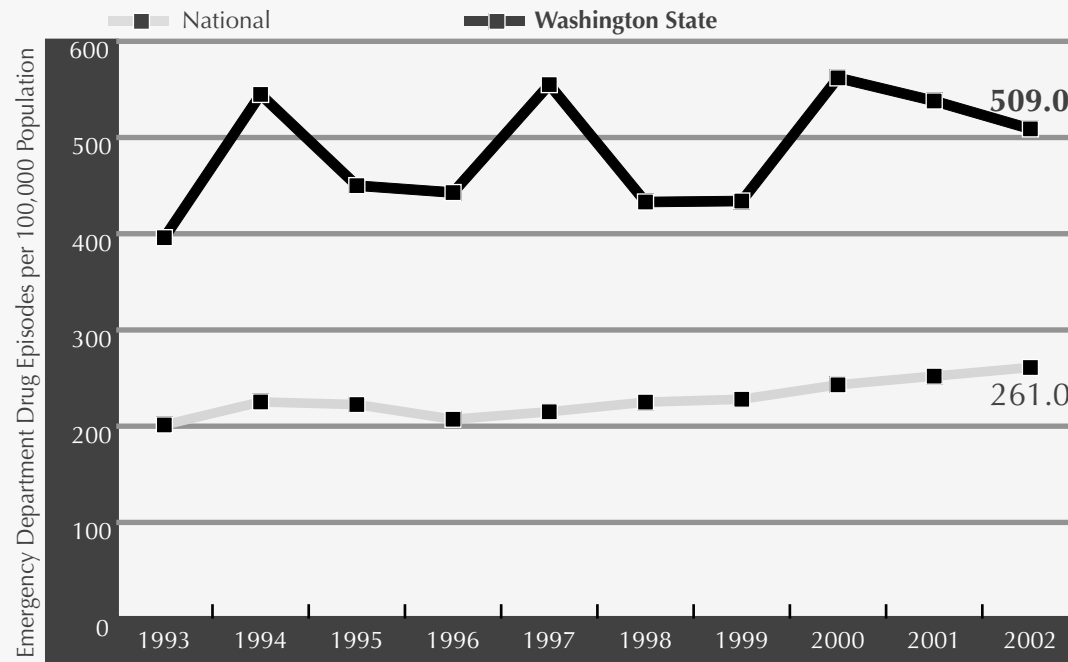
Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Drug-related death data provide a direct indication of the high human and social costs of drug use. Causes of death classified as drug-related include drug psychosis, drug dependence, suicide, and intentional and unintentional poisoning resulting from illicit drug use. Rising rates may be at least partially due to increases in prescription drug abuse-related deaths.

This graph indicates that Washington State continues to have a higher drug-induced death rate than the nation, with 688 such deaths in 2002. This rate is almost twice as high as it was in 1993.



The Seattle Metropolitan Area Has a Higher Rate of Drug-Related Emergency Department Visits than the Nation.

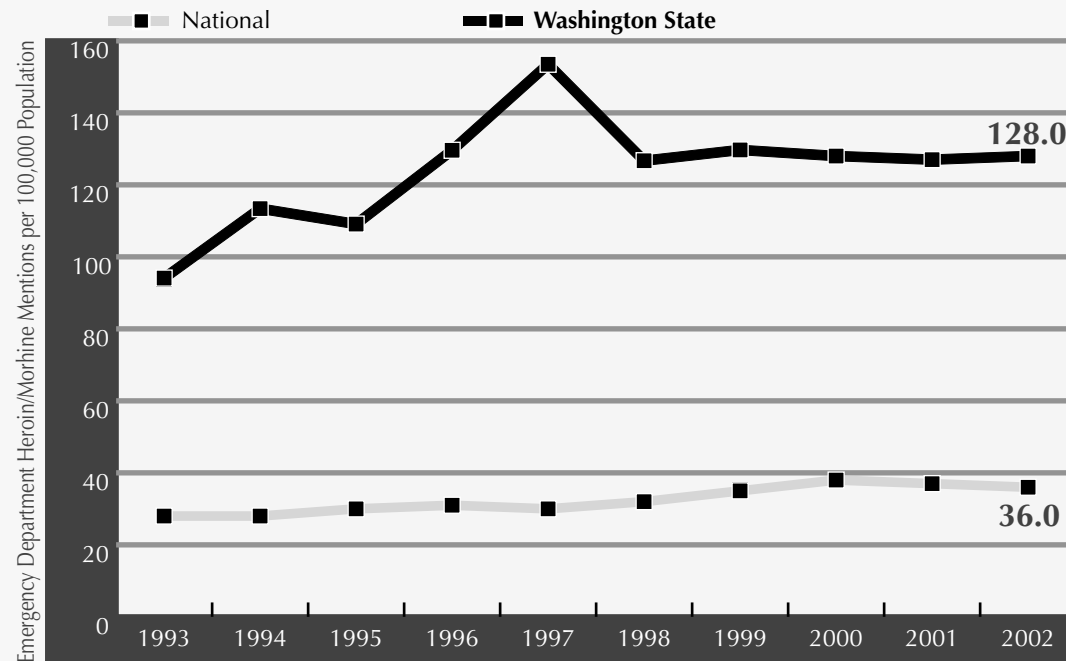


Source: Office of Applied Studies, Substance Abuse Mental Health Services Administration, Drug Abuse Warning Network (DAWN).

This graph indicates that the Seattle metropolitan area (King/Snohomish Counties – the only area in Washington State for which this data is available) has a higher rate of drug-related emergency department visits than the nation.

The federal Drug Abuse Warning Network defines an emergency department visit as drug-related whenever the visit is a result of the non-medical use of a drug. Non-medical drug use includes use of illicit drugs, use of prescription drugs in a manner inconsistent with accepted medical practice, and the use of over-the-counter drugs contrary to approved labeling.

Rate of Emergency Department Mentions of Heroin in the Seattle Metropolitan Area Have Stabilized Since 1997.



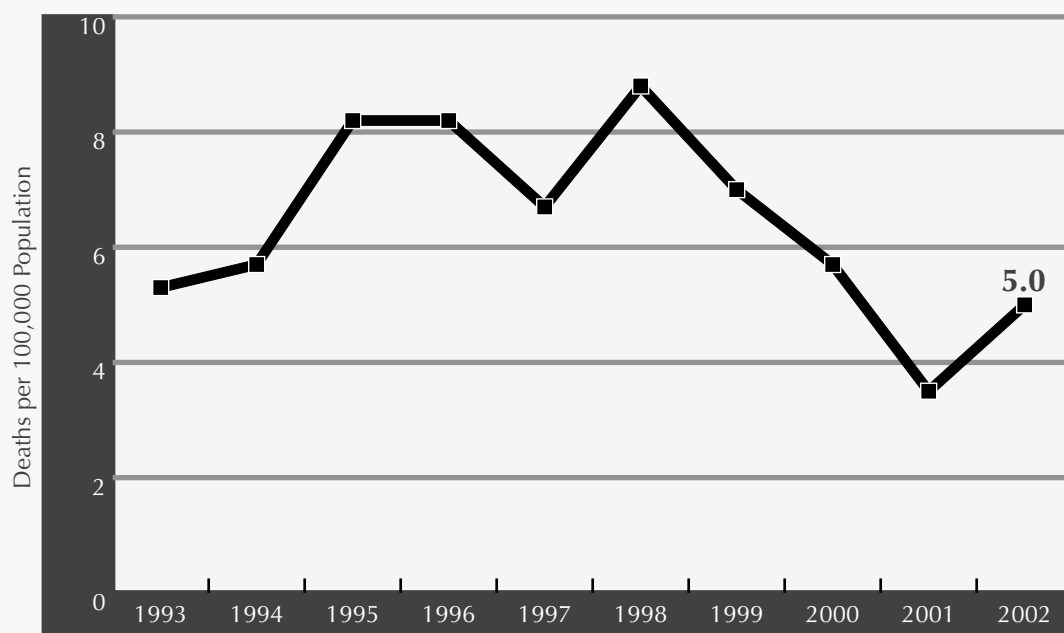
Source: Office of Applied Studies, Substance Abuse Mental Health Services Administration, Drug Abuse Warning Network (DAWN).

This graph indicates that after increasing rapidly between 1993 and 1997, the steep rise in emergency department mentions of heroin in the Seattle metropolitan area (King and Snohomish Counties – the only areas of the state for which data are available) has leveled off.

Some of this leveling may be due to expanded treatment capacity for individuals with heroin addiction. However, there are still substantial waiting lists for publicly funded opiate substitution treatment (methadone) in King County and throughout the state. As of February 2004, there were 683 individuals waiting for access to publicly funded methadone treatment on a list kept by the Seattle Needle Exchange. Because of limited treatment capacity and/or funding limitations, the average wait for an individual who has requested methadone treatment through the Needle Exchange is 18-24 months.¹

¹ Dr. Michael Hanrahan, Personal Communication – March 17, 2004. Seattle Needle Exchange, Public Health – Seattle-King County.

After Declining from a High in 1998, Rates of Heroin-Related Deaths in Seattle-King County are Again on the Rise.



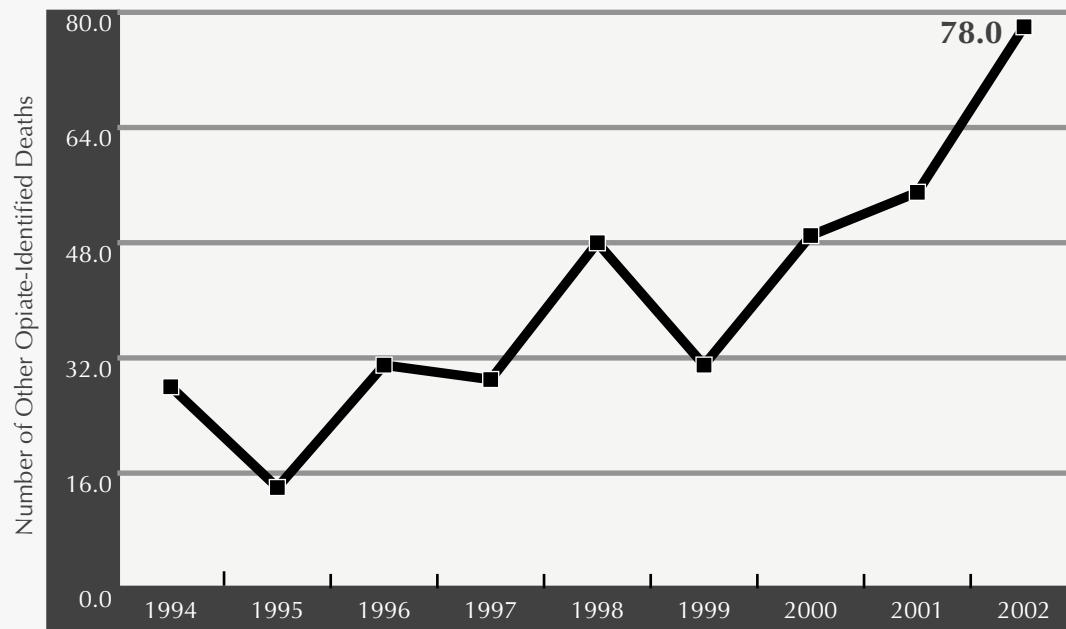
Source: King County Medical Examiner.

This graph indicates that, after declining for three straight years, Seattle-King County saw a 42.6% increase, from 61 in 2001 to 87 in 2002, in the number of heroin-related deaths.

Much of the earlier decline was likely due to public health measures adopted by city and county governments to address heroin addiction. King County authorized a 50% expansion in the number of opiate substitution treatment slots, and authorized a mobile methadone clinic. They have also provided preventive and limited substance abuse treatment services in the local criminal justice system, and expanded the availability of drug free housing for individuals in recovery. Recently, however, new treatment admissions have also declined, probably because effective treatment is resulting in longer treatment stays, and correspondingly fewer open treatment slots.¹ The opening of two new clinics in Snohomish County will likely result in more slots being available in King County programs for county residents.

¹ Banta-Green, C. et al., "Recent Drug Abuse Trends in the Seattle-King County Area," *Epidemiologic Trends in Drug Abuse*, June 2002.

The Number of Other Opiates* Identified in Drug-Caused Deaths in King County is Rising Rapidly.



Source: King County Medical Examiner.

The use of other opiates in pain management has risen substantially in recent years. As the population ages, and as medical science is better able to manage conditions which previously would have resulted in more rapid death, the use of pain management medications plays an important role in increasing quality of life. The Seattle office of the federal Drug Enforcement Administration reports that sales of prescription oxycodone to hospitals and pharmacies rose 235% between 1997-2002, and prescription methadone (non-opiate substitution treatment-related) rose 229%.¹

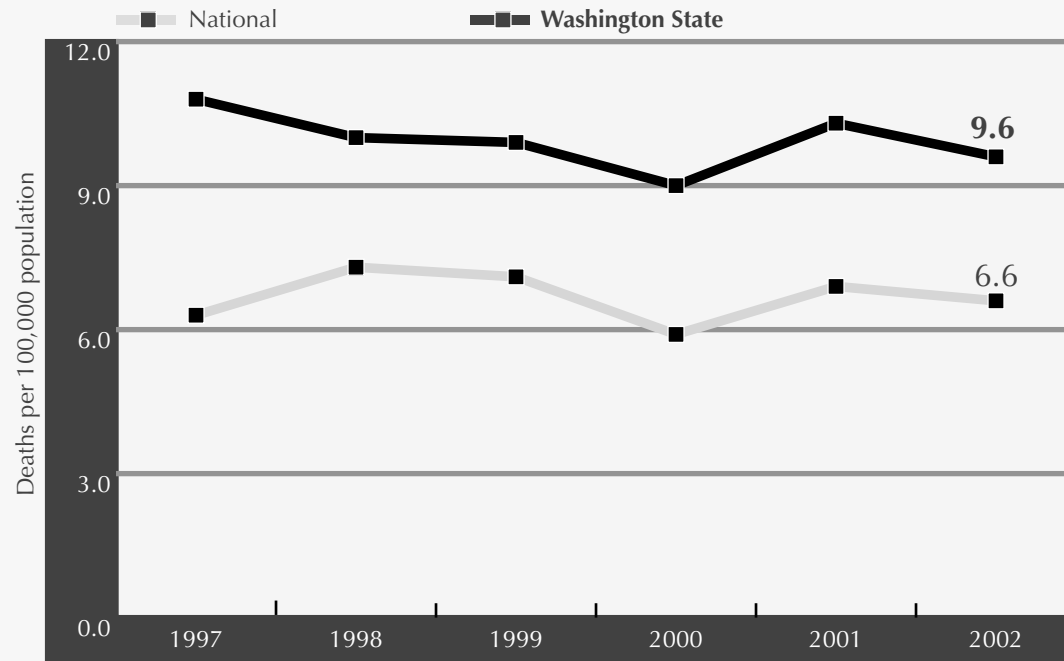
The expanded prescriptive use of other opiates, however, creates new opportunities for diversion and illicit use. There have been substantial increases in mentions of oxycodone and methadone among drug-related deaths over the past decade. OxyContin, illicit use of which has become epidemic in parts of the United States, is a time-release formulation of oxycodone.

**Defined as opiates other than heroin or morphine. These include: codeine, dihydrocodeine, fentanyl, hydrocodone, methadone, oxycodone, and propoxyphene. There are more mentions than deaths because some individuals had multiple other opiates detected at time of death.*

¹ Banta-Green, C. et al., "Recent Drug Abuse Trends in the Seattle-King County Area, December 2003," *Proceedings of the Community Epidemiology Workgroup*, Vol. II, December 2003.



Washington State Has a Higher Alcohol-Induced Death Rate than the Nation.



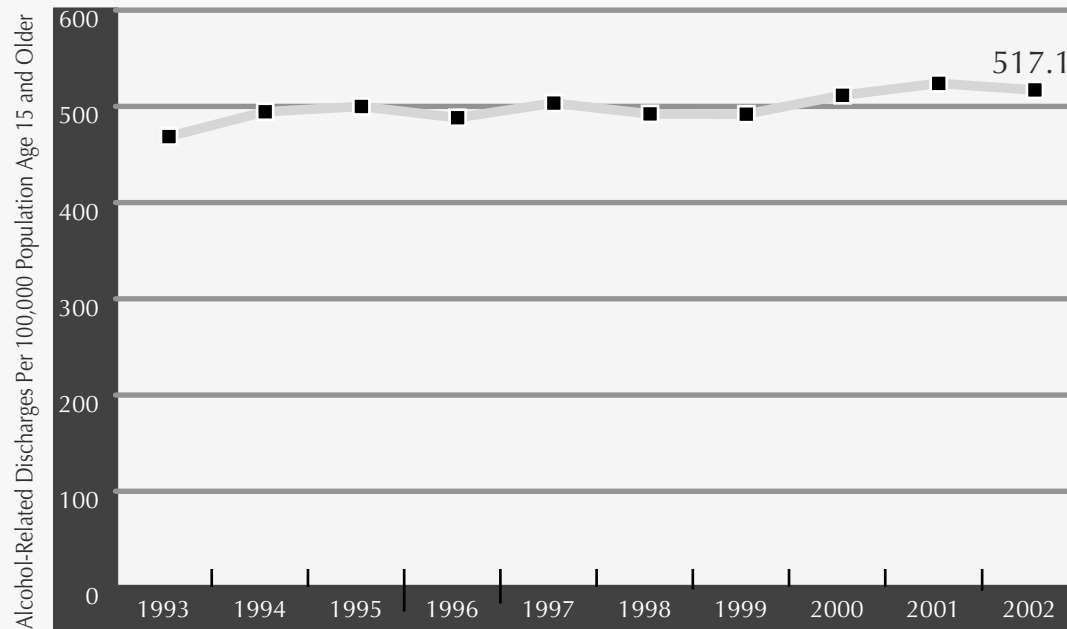
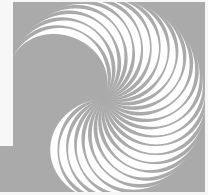
Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Alcohol-related death data provide a direction indication of the high human and social costs of alcohol use. Long-term heavy drinking increases risks for high blood pressure, heart rhythm irregularities (arrhythmias) and heart muscle disorders (cardiomyopathy), and stroke. It increases risks for certain forms of cancer, especially esophagus, mouth, throat, and larynx, for cirrhosis and other liver disorders, and worsens outcomes for individuals with hepatitis C. It is also linked with death from traffic crashes, falls, fires, and drowning, and is associated with homicide, suicide, domestic violence, and child abuse.¹

This graph indicates that Washington State has had a consistently greater alcohol-induced death rate than the nation. In 2002, it was 45% higher. There were 581 alcohol-induced deaths in Washington State in 2002.

¹ U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 26-4. Washington, DC: 2000.

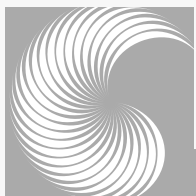
The Rate of Alcohol-Related Diagnoses in Acute Care Hospital Discharges in Washington State Has Been Slowly Increasing.



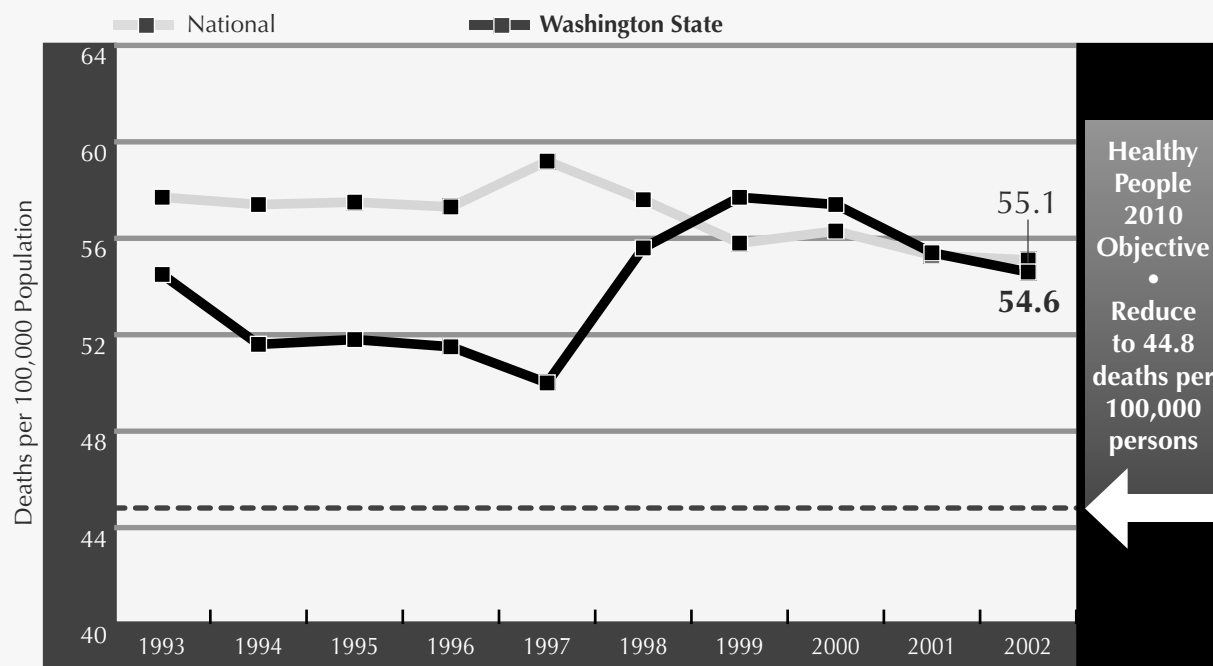
Source: Comprehensive Hospital Abstract Reporting System (CHARS), Washington State Department of Health.

Patients with alcohol-related diagnoses are discharged from acute care hospitals having been diagnosed with primary alcohol-related conditions such as alcohol psychoses, alcohol dependence syndrome, nondependent abuse of alcohol, and chronic liver disease and cirrhosis. These diagnoses do not include alcohol-related trauma such as injuries from motor vehicle crashes, or discharges associated with maternity stays. There were 24,726 patients with primary alcohol-related diagnoses discharged from Washington State acute care hospitals in 2002.

With funds from a grant from the federal Substance Abuse Mental Health Services Administration, the Division of Alcohol and Substance Abuse has initiated a program in six Washington hospitals whereby individuals affected by alcohol or other drugs who visit emergency departments are receiving brief interventions related to their substance abuse.



The Lung Cancer Death Rate in Washington State is Similar to That of the Nation.



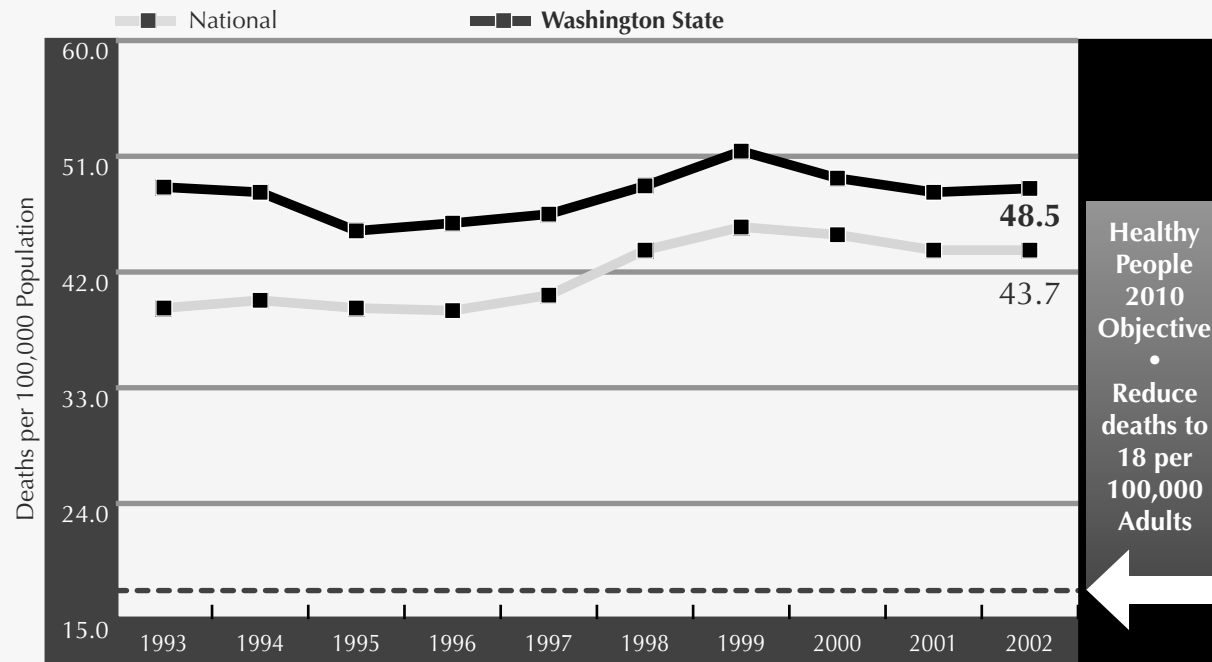
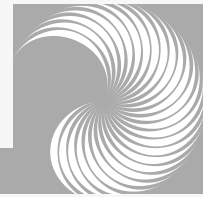
Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

The vast majority of lung cancer cases are attributable to cigarette smoking, accounting for 68-78% of lung cancer deaths among females, and 88-91% of deaths among males. Smoking cessation decreases the risk of lung cancer to 30-50% of that of continuing smokers after ten years of abstinence.¹

This graph indicates that, while lower for most of the past decade, lung cancer death rates in Washington State are now similar to those of the nation. Lung cancer is the most common category of cancer mortality in the U.S.

¹ U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 3-12. Washington, DC: 2000.

The Death Rate in Washington State from Chronic Lower Respiratory Disease is Higher than the Nation's.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Chronic lower respiratory disease (formerly known as chronic obstructive pulmonary disease) occurs most often in people over age 65. Between 80-90% of cases are attributable to cigarette smoking.¹

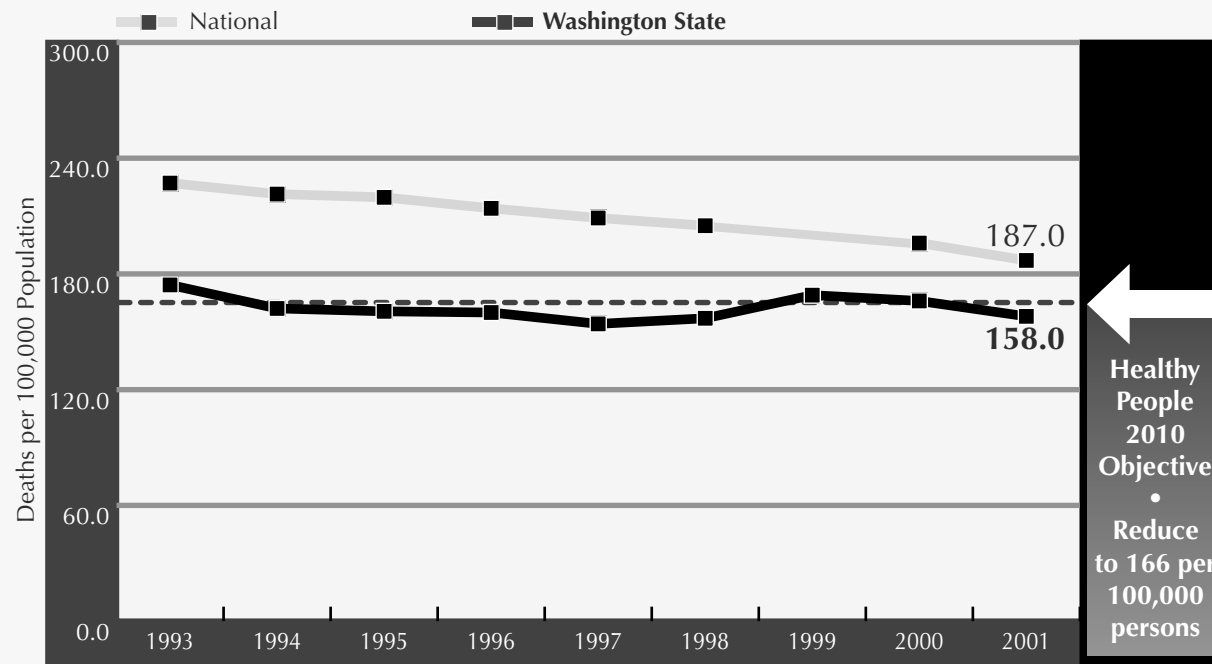
This graph indicates that the mortality rate from chronic lower respiratory disease in Washington State is higher than it is nationally. Chronic lower respiratory disease includes chronic bronchitis and emphysema, both of which are characterized by irreversible airflow obstruction. Both conditions often exist together.²

¹ U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 24-8. Washington, DC: 2000.

² *Ibid.*



The Coronary Heart Disease Death Rate in Washington State is Lower than the National Rate.



Source: National and state data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention.

Heart disease is the leading cause of mortality in the United States, and coronary heart disease accounts for the largest portion of heart disease deaths. About 12 million Americans have coronary heart disease. Prevention strategies included reducing blood cholesterol, high blood pressure, obesity and excessive weight gain, and cigarette smoking, as well as increasing amounts of physical activity.¹ In 2000, obesity and physical activity caused 400,000 U.S. deaths, 16% of the total, and is now considered the nation's second leading killer, after tobacco use.²

¹ U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 12-6. Washington, DC: 2000.

² Mokdad, A. et al., "Actual Causes of Death in the United States, 2000," *Journal of the American Medical Association* 291(10), March 10, 2004.

The Problem: Substance Abuse Prevalence & Trends

**AREAS OF
SUBSTANCE
ABUSE
IMPACT**

Birth Defects/
Complications

Accident
Risks

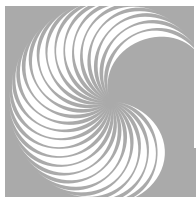
Health
Consequences

Infectious
Diseases

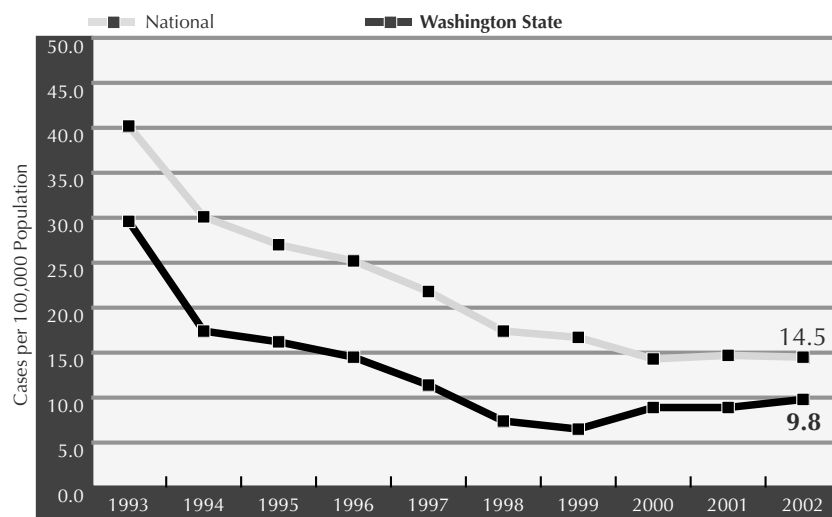
Crime

Violence

Family
Distress



The Reported AIDS Case Rate in Washington State is Lower than the Nation.*



Source: National and state data from the Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report 14*, October 2003.

From January 1982 through January 2004, 10,955 AIDS (Acquired Immune Deficiency Syndrome) cases were reported in Washington State, and there were 5,922 deaths from the disease. As of January 2004, there were 4,993 Washington residents living with AIDS. Some 19% of AIDS cases in Washington State were traceable to possible exposure from injection drug use, substantially lower than the percentage of cases attributed to injection drug use nationally.¹ Studies have shown that cities that implemented needle exchange programs early in the AIDS epidemic – such as Seattle and Tacoma – have much lower infection rates among injection drug users (IDUs).

This graph indicates that the reported AIDS case rate in Washington is consistently lower than the nation's. Since 1993, the AIDS case rate has generally been in decline, reflecting the effectiveness of new treatments in preventing HIV (human immunodeficiency virus) infection from progressing to AIDS. However, the recent rise in the AIDS case rate in Washington State may reflect a larger number of individuals seeking treatment, a decline in the death rate, or the growing failure of anti-retroviral medications to work over sustained period of time in preventing HIV infection from progressing to AIDS.² Nationally, well over half of individuals diagnosed with AIDS live longer than seven years after the diagnosis.³

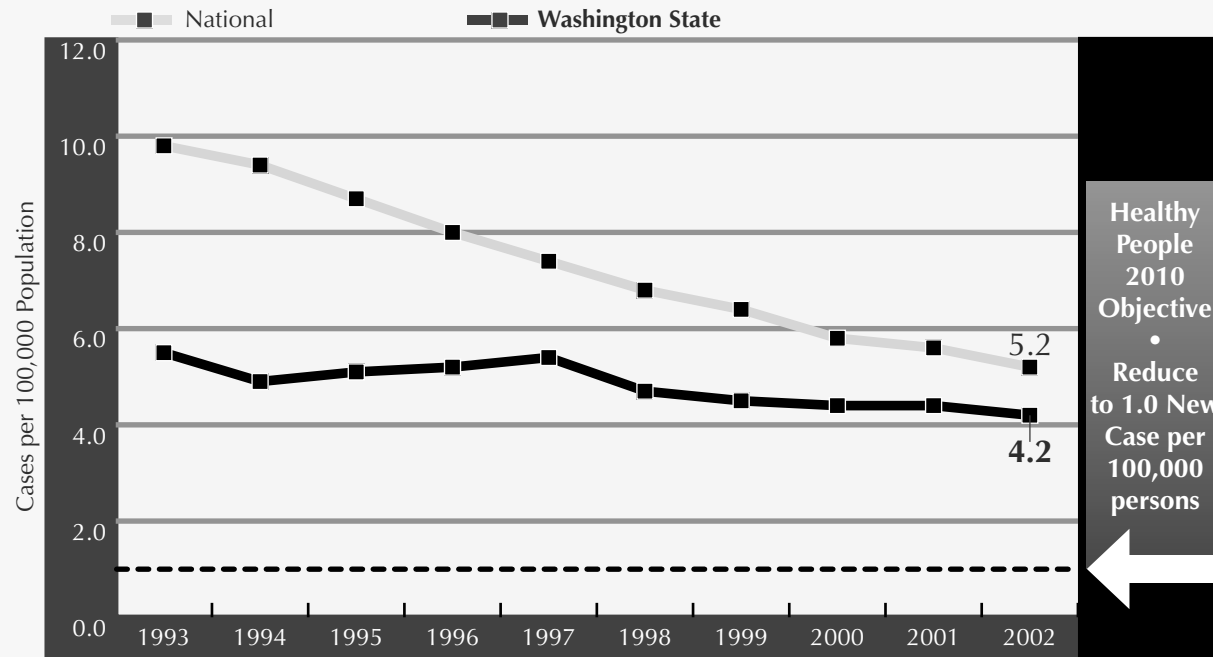
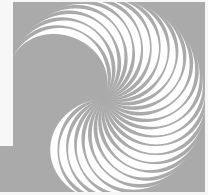
* Case counts are provisional; reporting is considered incomplete for several years.

¹ Office of HIV Prevention and Education, Washington State Department of Health, 2004.

² Infectious Disease and Reproductive Health Unit, Washington State Department of Health, 2003.

³ Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report 14*, October 2003.

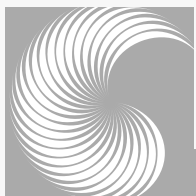
Washington State Has a Lower Rate of New Tuberculosis Cases Than the Nation.



Source: National data from the Division of Tuberculosis Elimination, Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention. State data from Assessment Unit – Infectious Disease and Reproductive Health, Washington State Department of Health.

Multiple risk factors, including poverty, homelessness, substance abuse, gaps in health care infrastructure, and the human immunodeficiency virus (HIV) epidemic, are associated with new tuberculosis cases. Ensuring that patients with active tuberculosis infection complete curative therapy early is essential to curbing the disease's spread. Washington State has adopted treatment provider regulations to screen all chemical dependency patients to help prevent and control the spread of the disease.

This graph indicates that Washington State has had a consistently lower tuberculosis rate than the nation. After a national and state resurgence in the early 1990s, the tuberculosis epidemic has receded.



The Rate of Acute Hepatitis B in Washington State Has Declined in the Past Decade.



National data from the Epidemiology Program Office, National Notifiable Disease Surveillance System, Centers for Disease Control and Prevention. State data from Washington State Department of Health, *Annual Communicable Disease Report – 2002*.

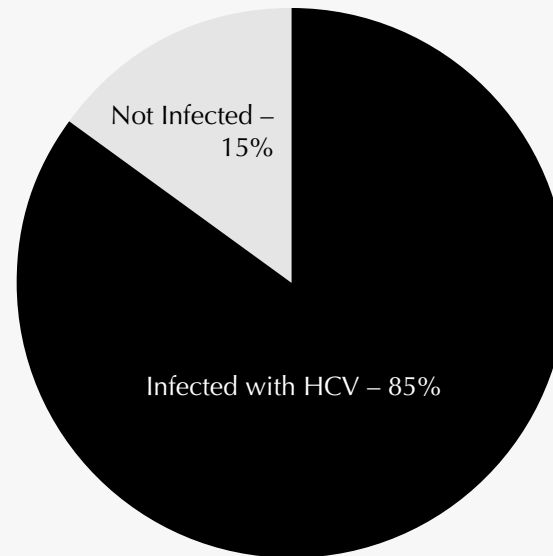
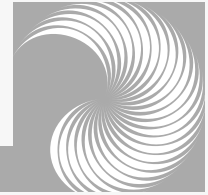
Injection drug uses is a major risk factor for hepatitis B infection. Most cases occur in young adult risk groups, including persons with a history of multiple sex partners, men who have sex with men, injection drug users, incarcerated persons, and household and sex contacts of infected partners. It may also be transmitted perinatally.¹

This graph indicates that the rate of acute hepatitis B cases in Washington State has declined over the past decade. Hepatitis B is a serious disease that attacks the liver, and chronic hepatitis B infection, which may be carried without sign of infection, is associated with cirrhosis, liver cancer, and liver failure. The greatest decline in infections over the past decade has been in children and adolescents, and associated with routine childhood vaccination.²

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 14-15. Washington: CD 2000.

² Centers for Disease Control and Prevention, "Incidence of Acute Hepatitis B – United States, 1990-2002," *Morbidity and Mortality Weekly Report* 52(51), January 2, 2004.

Some 85% of Injection Drug Users in King County are Infected with Hepatitis C Virus (HCV).



Source: Community Epidemiology Work Group, National Institute on Drug Abuse, National Institutes of Health, *Recent Drug Trends in the Seattle-King County Area*, December 2003.

Of the 15,000-18,000 injection drug users (IDUs) in Seattle-King County, 85% are infected with the hepatitis C virus (HCV). Recent incidence studies indicate that 21% of non-infected Seattle-area IDUs acquire HCV each year.¹

HCV is the most common chronic bloodborne viral infection in the United States, affecting an estimated 2.7 million people in the U.S., and causes an estimated 8,000-10,000 deaths each year from cirrhosis and liver cancer.² As many as 100,000 people in Washington State are believed to be infected, with 250 deaths annually.³ It is the leading reason for liver transplantation in the U.S. Even moderate alcohol use is known to exacerbate liver injury resulting from HCV.

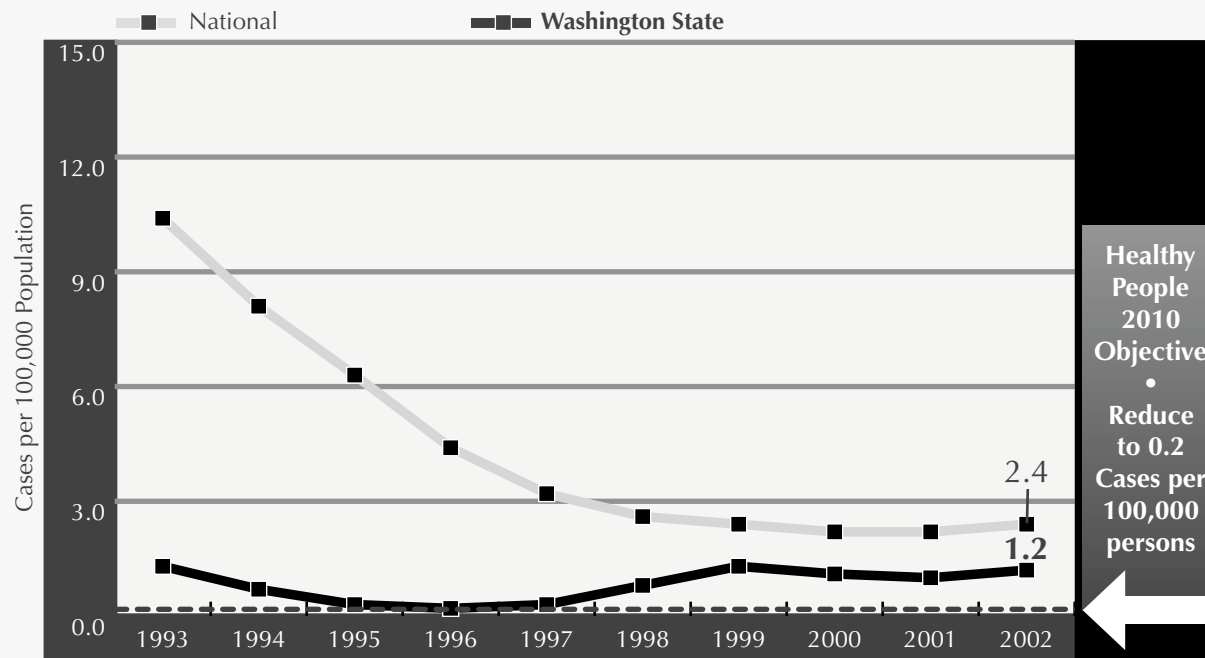
¹ Banta-Green, C. et al., "Recent Trends in the Seattle-King County Area, December 2003," *Proceedings of the Community Epidemiology Work Group* Vol. II, December 2003.

² National Center for Infectious Diseases, *Viral Hepatitis C Fact Sheet*. Atlanta: GA: Centers for Disease Control and Prevention, 2004.

³ Office of Epidemiology, "Notifiable Conditions: Hepatitis C (HCV)," Washington State Department of Health, October, 2002.



Washington State is Experiencing a Significant Increase in the Rate of Primary and Secondary Syphilis.



Source: National data from the National Center for HIV, STD, and TB Prevention, Centers of Disease Control and Prevention. State data from Washington State Department of Health, *Annual Communicable Disease Report – 2002*.

The spread of sexually transmitted diseases (STDs), including syphilis, is often linked to the use of alcohol and other drugs. The introduction of new illicit substance use into a community often can substantially alter sexual behavior in high-risk sexual networks. Increases in the exchange of sex for drugs, increases in the number of anonymous sex partners, decreases in motivation to use barrier protection, lowered ability to negotiate safe sex practices, and declines in attempts to seek medical treatment can all fuel epidemic spread of STDs.¹

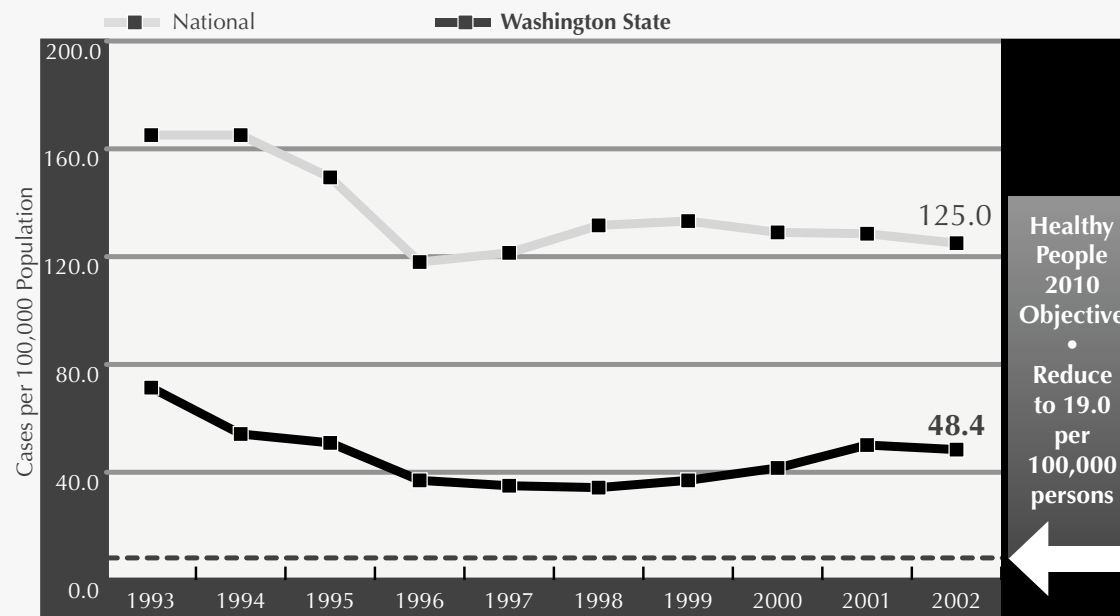
From a low of nine cases in 1996, Washington State has experienced a substantial increase in the number of primary and secondary (P&S) syphilis cases. There were 70 cases in 2002, 50 of them in King County. Transmission is strongly associated with men having sex with men², and may be associated with substance abuse, notably methamphetamine and inhaled nitrites.³ Counts of P&S syphilis cases may understate the problem, as cases are often diagnosed after they have gone beyond the primary and secondary stages and become latent.

¹ U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 25-5. Washington, DC: 2000.

² Washington State Department of Health, *Annual Communicable Disease Report – 2002*. Olympia, WA: 2003.

³ Public Health, Seattle & King County, *Screening Guidelines for Men Who Have Sex with Men (MSM)*. Seattle, WA: 2001.

Gonorrhea Rates in Washington State Have Increased 50% Since 1998.



Source: National data from the National Center for HIV, STD, and TB Prevention, Centers of Disease Control and Prevention. State data from Washington State Department of Health, *Annual Communicable Disease Report – 2002*.

The spread of sexually transmitted diseases (STDs), including gonorrhea, is often associated with substance abuse. Increases in the exchange of sex for drugs, increases in the number of anonymous sex partners, decreases in motivation to use barrier protection, lowered ability to negotiate safe sex practices, and declines in attempts to seek medical treatment can all fuel epidemic spread of STDs.¹

While lower than historical levels, Washington State is experiencing a serious resurgence in gonorrhea cases, from 1,948 cases in 1998 to 2,925 cases in 2002, representing a 50.2% increase. Much of this increase is associated with men having sex with men in King County, where the rate has more than doubled since 1998, and may be as much as six times greater than for heterosexuals.²

Gonorrhea infections are a major cause of pelvic inflammatory disease, tubal infertility, ectopic pregnancy, and chronic pelvic pain. Epidemiologic studies indicate that gonococcal infections such as gonorrhea may facilitate HIV transmission.³

¹ U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 25-5. Washington, DC: 2000.

² STD/TB Services and Infectious Disease and Reproductive Health Assessment Unit, Washington State Department of Health. *Sexually Transmitted Disease Morbidity, 2001 -- Washington State*. Olympia, WA: 2002.

³ Washington State Department of Health, *Annual Communicable Disease Report – 2002*. Olympia, WA: 2003.

The Problem: Substance Abuse Prevalence & Trends

**AREAS OF
SUBSTANCE
ABUSE
IMPACT**

Birth Defects/
Complications

Accident
Risks

Health
Consequences

Infectious
Diseases

Crime

Violence

Family
Distress



Alcohol-Related Motor Vehicle Arrest Rates in Washington State Have Remained Steady for the Past Seven Years.

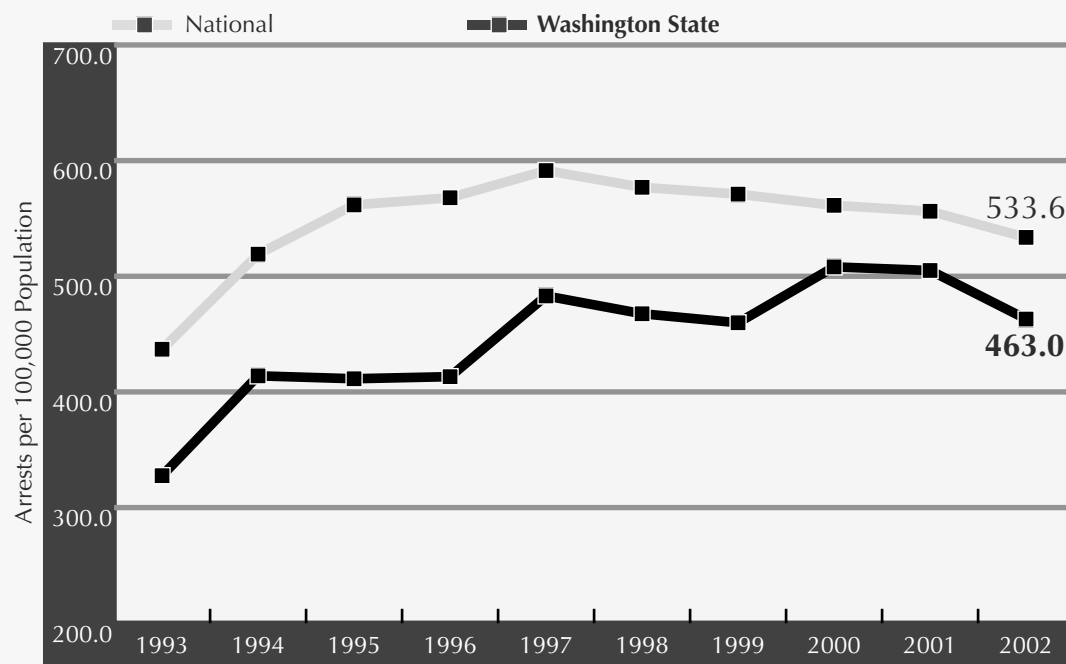


Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States Annual Reports*. State data from Washington State Patrol Breathalyzer Database.

Data for alcohol-related motor vehicle arrests may reflect a jurisdiction's laws, enforcement policy, financial resources, and officer discretion, in addition to the actual number of alcohol-related driving incidents. Washington State enacted new alcohol-related motor vehicle statutes in 1998 – including lowering the blood alcohol concentration for proof of intoxication from .10 to .08, and zero tolerance for drivers under age 21. While these statutes have not resulted in higher arrest rates, they have resulted in lower alcohol-related motor vehicle fatality rates.¹

¹ Salzberg, Philip, and Anne Yamada. *Drunk Driving Trends in Washington State: Evaluation of the 1998 DUI Laws*. Olympia, WA: Traffic Research and Data Center, Washington State Traffic Safety Commission, 2002.

Washington State Has a Lower Arrest Rate for Drug Abuse Violations than the Nation.



Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports. State data from Washington Association of Sheriffs & Police Chiefs, *Crime in Washington State* annual reports.

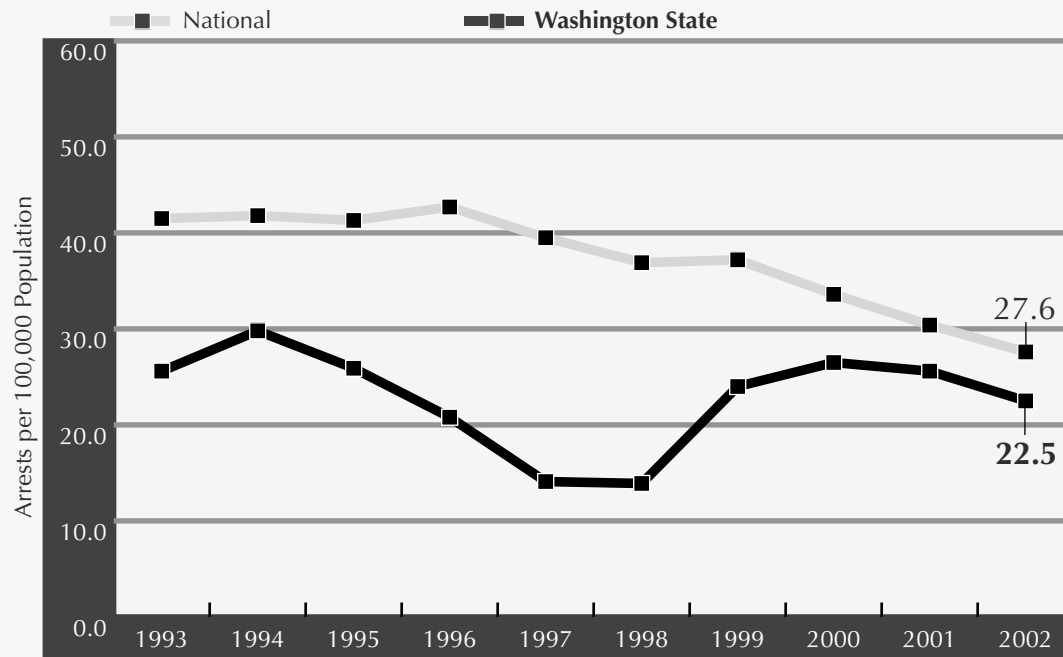
This graph indicates that while the rate of arrests for drug abuse violations in Washington State is now declining, in 2002 it is 41.3% higher than it was in 1993. Arrests made for drug abuse violations provide a direct measure of illegal activity related to substance abuse. A drug abuse violation is any transgression of state or local laws that results from the unlawful possession, sale, use, cultivation, or manufacture of illicit drugs. Arrest data may reflect a jurisdiction's financial resources, enforcement policy, and officer discretion, as well as the actual level of drug-related criminal activity.

There were 27,975 arrests for drug abuse violations in Washington State in 2002. From November 2002 through February 2003, 73.6% of male arrestees booked into the Snohomish County Jail tested positive for illicit drugs.¹ Under sentencing reform legislation enacted in 2002, an individual arrested and filed upon by the prosecutor for a drug-related offense is now more likely to receive chemical dependency treatment as part of a diversion program or in lieu of incarceration after conviction.

¹ Gilson, M., and Kabel, J., *The Snohomish County Arrestee Substance Abuse (SCASA) Study: Characteristics of Drug Use Among Arrestees Booked Into Snohomish County Corrections Including Comparisons to Booked Arrestees in King and Spokane Counties*. Olympia, WA: Looking Glass Analytics, 2003.



Arrest Rates in Washington State for Prostitution are Below the National Rate.



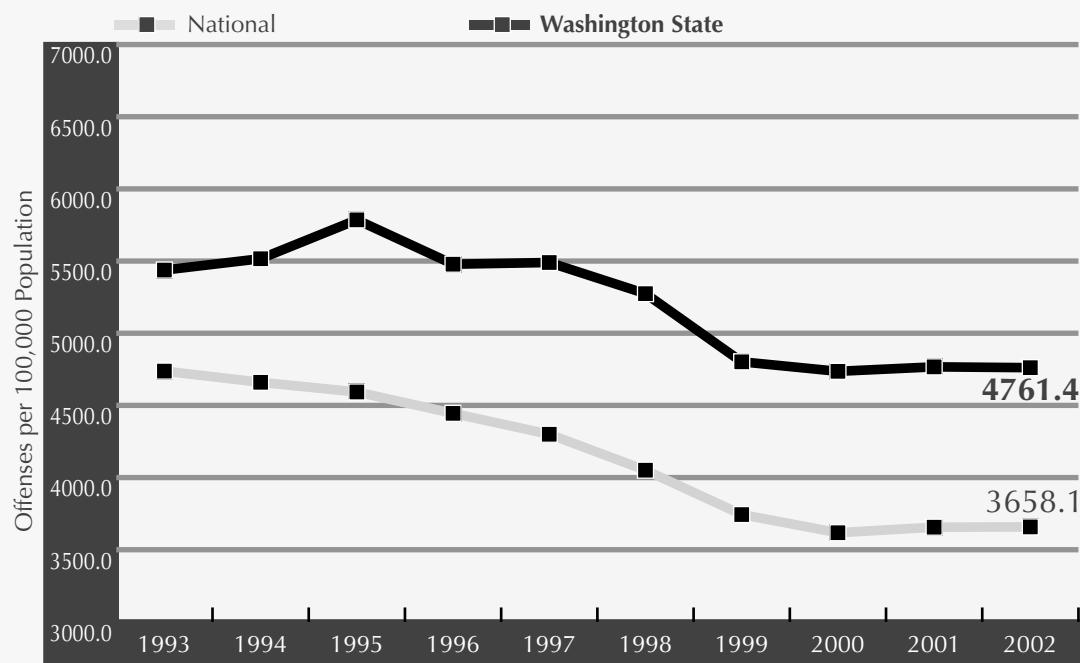
Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports. State data from Washington Association of Sheriffs & Police Chiefs, *Crime in Washington State* annual reports.

The Arrestee Drug Abuse Monitoring Program reported that 78.3% of those arrested for prostitution in Seattle in 1999 tested positive for illegal drugs, mostly for cocaine.¹ Prostitution is associated with the spread of HIV/AIDS and other sexually transmitted diseases.

This graph indicates that arrest rates for prostitution in Washington State are significantly lower than that of the nation. Of the 1,358 prostitution arrests in Washington State in 2002, 426 (representing 31.4% of the total) were male. It should be noted that arrest rates may be influenced by a jurisdiction's financial resources, enforcement policy, and officer discretion, as well as the actual level of criminal activity.

¹ Office of Justice Programs, National Institute of Justice, *Arrestee Drug Abuse Monitoring Program 1999 Annual Report*. Washington, DC: U.S. Department of Justice, 2000.

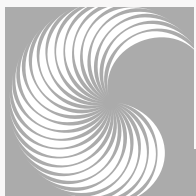
Washington State Has a Higher Property Crime Index than the Nation.



Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports. State data from Washington Association of Sheriffs & Police Chiefs, *Crime in Washington* annual reports.

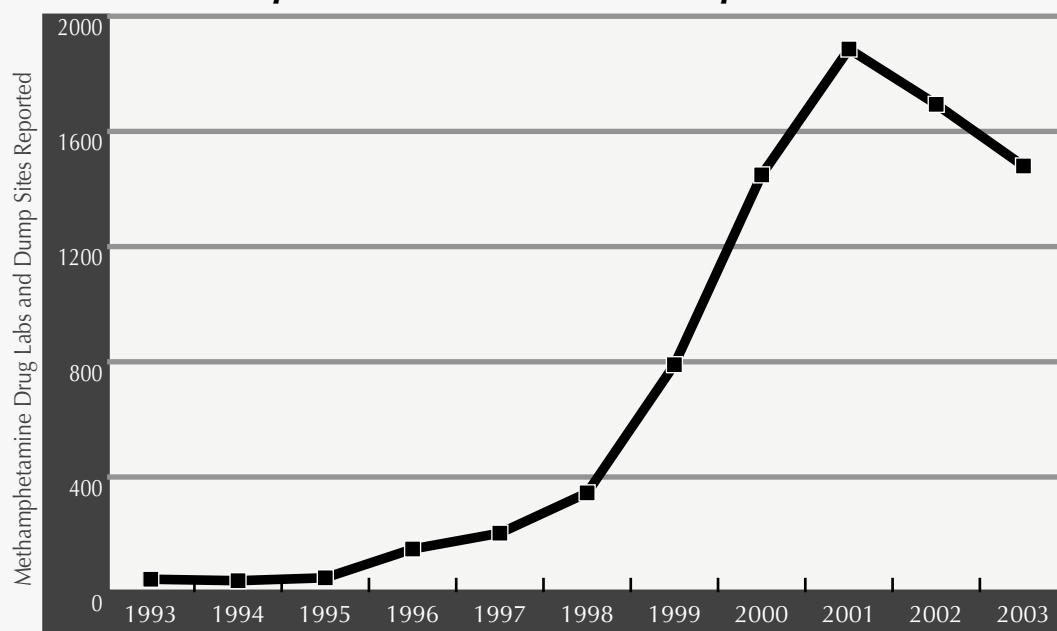
The Arrestee Drug Abuse Monitoring Program found that in 2000, 73.4% of males arrested for property offenses in King County, and 71.5% arrested for property offenses in Spokane County tested positive for illegal drugs.¹

This graph indicates that the Washington State property crime index is higher than the nation's, but is in a downward trend. The property crime index includes burglary, larceny-theft, motor vehicle theft, and arson. Distinct from arrest data, this index counts one offense for each victim who reports a property crime to the police, regardless of the number of offenders involved.



The Number of Reported Methamphetamine Laboratories and Dump Sites in Washington State Continues to Drop.

Number of Reported Meth Labs and Dump Sites



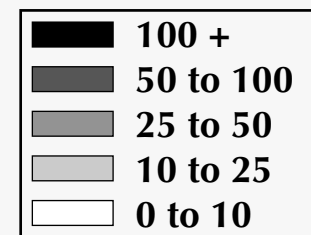
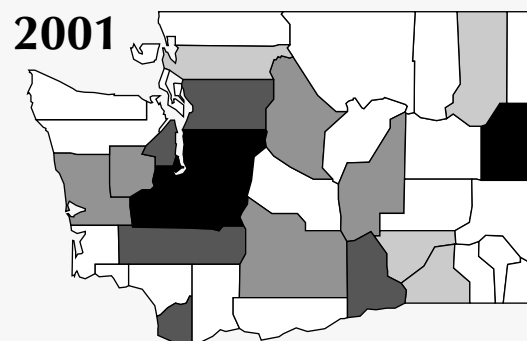
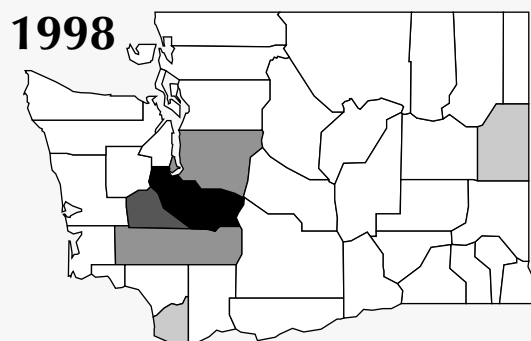
Source: Washington State Department of Ecology, 2004.

This graphic indicates that after dramatic increases since 1994, the number of illegal methamphetamine (meth) laboratories and dump sites in Washington State dropped by 12.8% in 2003. This followed a 10.2% decline in 2002. The largest number of reports in 2003 came from Pierce (466), King (202), Snohomish (98), Thurston (96), and Spokane (91) Counties. The largest decline was in Spokane County (from 189 in 2002, to 91 in 2003.)

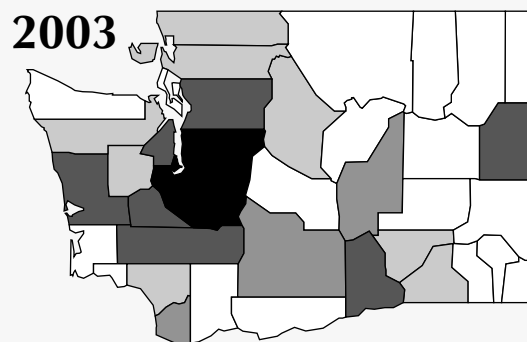
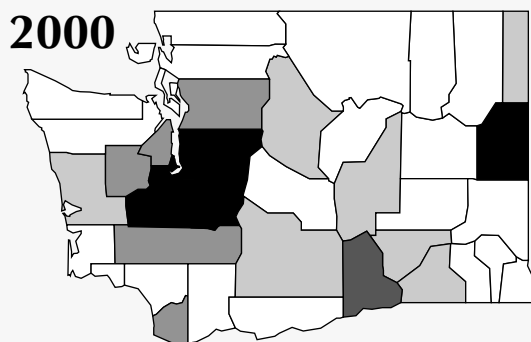
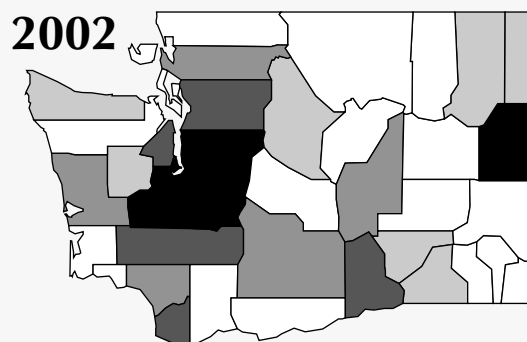
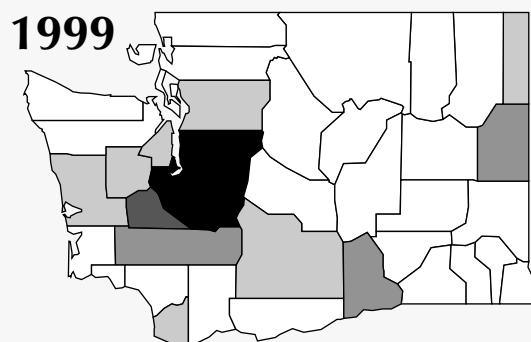
It is likely, but not yet substantiated, that the number of meth lab reports reflects the level of illicit use of the drug in the community. It is also possible, however, that drug dealers are now importing finished product from elsewhere, rather than manufacturing it, and that there is now a smaller number of large labs, accounting for the documented decline. It is now estimated that only one third of the methamphetamine used in Washington is produced in-state.¹ Anecdotal reports also suggest that meth users may be increasingly turning to heroin use.

¹ Banta-Green, C., *Washington State Drug Use Epidemiology*. Seattle, WA: Alcohol & Drug Abuse Institute, University of Washington, 2003.

Distribution of Methamphetamine Drug Laboratories and Dump Sites Reported by County



Source: Washington State Department of Ecology



These maps indicate that while report of drug labs and dump sites have declined in the past two years, they are still much more widespread than they were six years ago. In 1993, only one county – Pierce – had as many as ten reports. There have been huge increases since then: in Pierce from 12 to 466; King, from seven to 202; Thurston, from 4 to 96; Spokane, from zero to 89; Benton from zero to 82; Grays Harbor from 2 to 50. The epidemic has spread rapidly to virtually every part of the state.

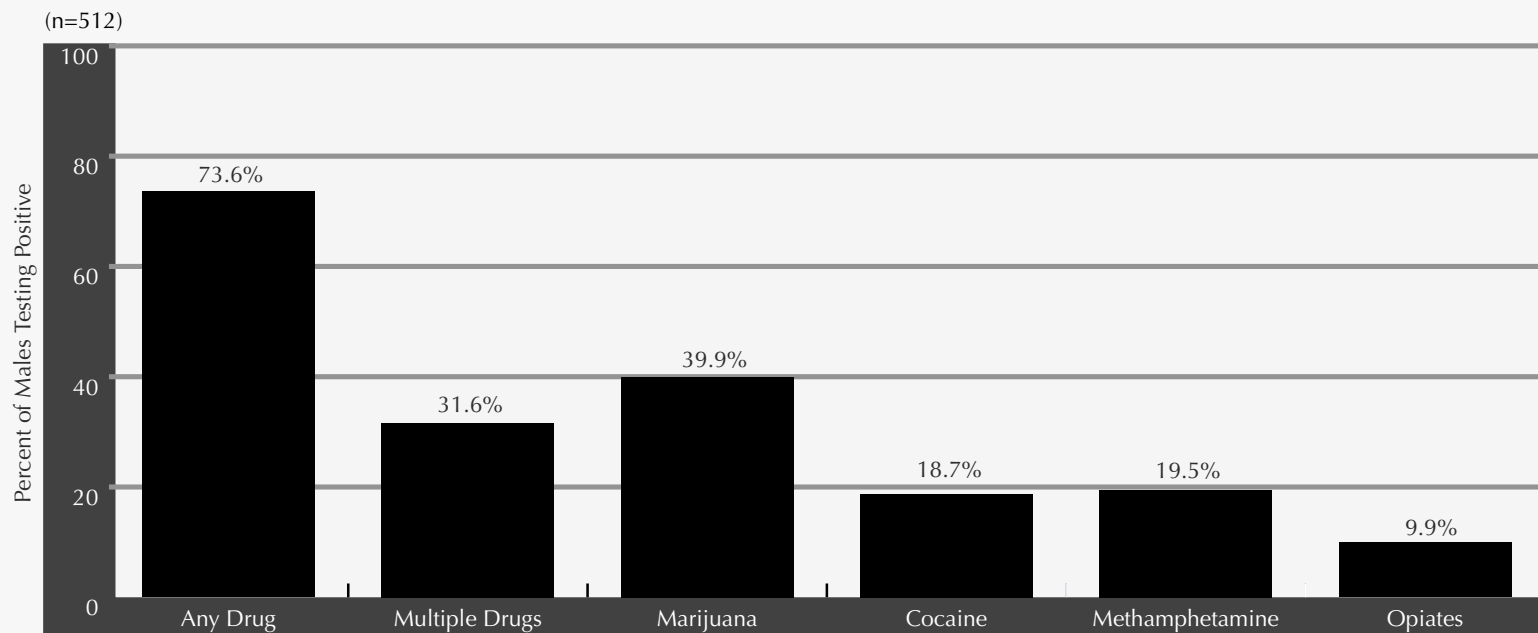
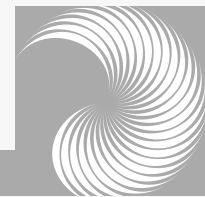


Number of Reported Methamphetamine Laboratories and Dump Sites in Washington State

County	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Adams	-	-	-	-	1	-	1	-	3	4	4
Asotin	-	-	-	-	-	-	1	1	5	3	4
Benton	-	-	1	3	4	7	38	52	85	87	82
Chelan	1	-	1	1	-	-	2	14	34	15	13
Clallam	-	1	1	1	3	3	-	1	3	10	2
Clark	1	3	3	12	20	12	16	34	57	57	35
Columbia	-	-	-	-	-	-	1	3	2	1	4
Cowlitz	1	-	1	3	9	2	8	7	9	28	18
Douglas	-	-	-	-	-	1	1	6	5	7	4
Ferry	-	-	-	-	-	-	-	7	4	0	0
Franklin	-	-	-	-	-	1	8	10	15	11	13
Garfield	-	-	-	-	-	-	2	-	-	4	1
Grant	-	-	1	-	-	-	2	19	27	46	34
Grays Harbor	2	2	1	3	5	5	16	24	41	32	50
Island	-	-	1	-	1	2	5	1	5	5	14
Jefferson	-	-	-	-	1	1	2	7	6	4	12
King	7	7	10	23	17	48	107	231	271	241	202
Kitsap	1	-	-	3	-	1	21	45	54	60	50
Kittitas	1	-	1	-	-	1	3	-	5	3	5
Klickitat	-	-	1	1	1	3	-	6	4	2	1
Lewis	2	3	4	7	9	31	33	43	61	83	67
Lincoln	-	-	-	-	-	-	-	-	5	3	2
Mason	2	-	-	4	4	10	21	32	30	22	15
Okanogan	-	-	-	-	2	3	2	2	3	3	1
Pacific	-	-	1	-	4	1	6	2	3	4	3
Pend Oreille	1	-	-	-	2	6	10	12	5	12	6
Pierce	12	17	17	53	42	129	318	545	589	438	466
San Juan	-	-	-	-	-	-	-	-	1	1	0
Skagit	1	-	1	-	-	4	2	5	11	34	12
Skamania	-	-	-	-	-	-	2	1	2	3	3
Snohomish	2	-	-	7	6	5	13	37	69	83	98
Spokane	-	1	2	1	7	11	36	137	248	189	91
Stevens	-	-	-	1	1	-	5	4	15	10	3
Thurston	4	2	6	25	63	58	86	139	151	115	96
Wahkiakum	-	-	-	-	-	-	1	-	2	2	2
Walla Walla	-	-	-	-	-	2	8	12	16	15	16
Whatcom	1	-	-	-	-	-	-	-	5	9	24
Whitman	-	-	-	-	-	-	-	1	3	4	0
Yakima	2	-	1	5	1	2	12	14	36	43	27
TOTAL	41	36	54	153	203	349	789	1,454	1,890	1,693	1,480

Source: Washington State Department of Ecology.

Almost Three Quarters of Male Arrestees Booked Into the Snohomish County Jail Between November 2002 – February 2003 Tested Positive for Drugs.



Source: Gilson, M., and Kabel, J., *The Snohomish County Arrestee Substance Abuse (SCASA) Study*. Olympia, WA: Looking Glass Analytics, 2003.

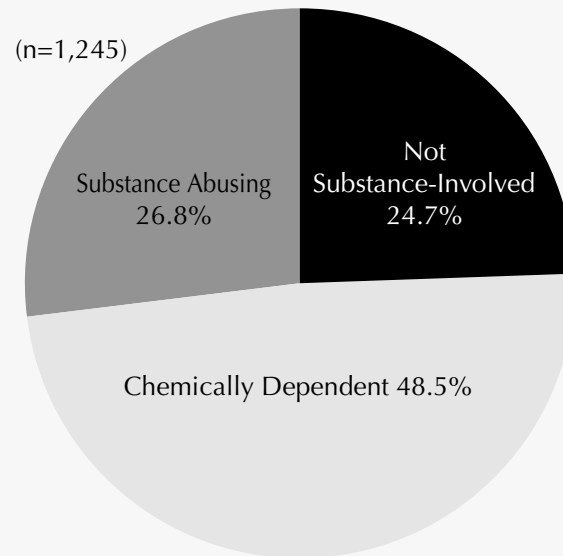
Modeled on an approach pioneered by the recently defunded federal Arrestee Drug Abuse Monitoring Program, males arrested and booked into the Snohomish County Jail between November 2002 – February 2003 were tested for drug use via urine sampling, and interviewed. Almost three quarters (73.6%) tested positive for illicit drugs. Some 39.9% of arrestees were classified as drug-dependent, with 23.7% classified as dependent upon alcohol. Arrestees that reported heavy substance use were more likely to have been arrested in the past 12 months, reported a greater number of lifetime arrests, and reported spending more time in jail than those who did not report heavy substance use.

Only 29% of Snohomish County arrestees reported receiving any treatment for chemical dependency during the previous year.¹

¹ Gilson, M., and Kabel, J., *The Snohomish County Arrestee Substance Abuse (SCASA) Study: Characteristics of Drug Use Among Arrestees Booked Into Snohomish County Corrections Including Comparisons to Booked Arrestees in King and Spokane Counties*. Olympia, WA: Looking Glass Analytics, 2003.



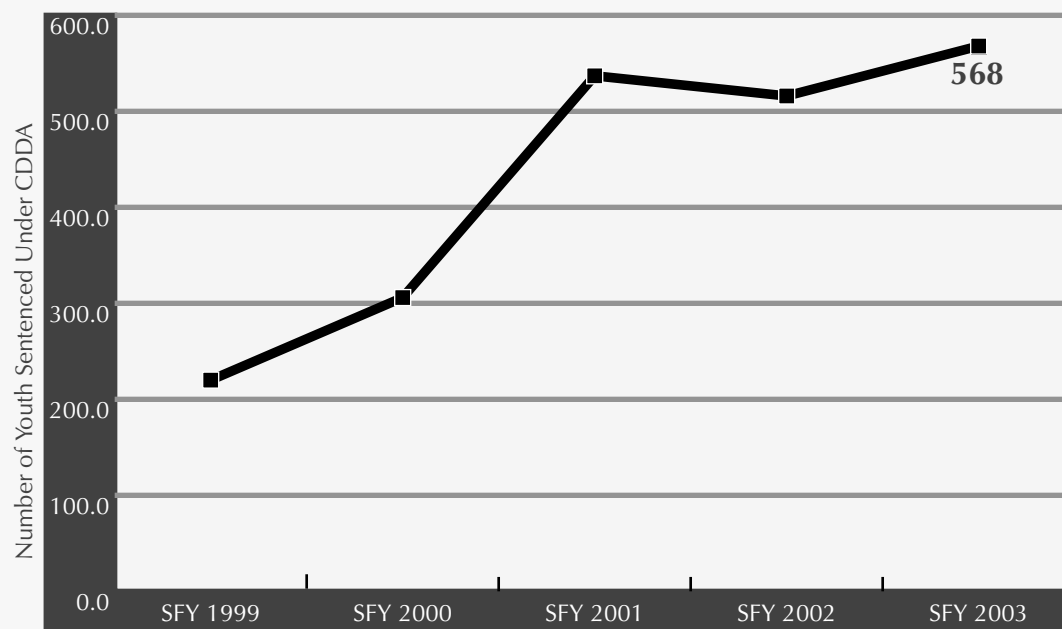
Approximately Three Quarters of Youth Entering Juvenile Rehabilitation Administration Facilities Have Substance Abuse-Related Problems.



Source: Client Tracking System, Juvenile Rehabilitation Administration, Washington State Department of Social and Health Services, May 2004.

Three out of four youths entering Juvenile Rehabilitation Administration (JRA) institutions have substance abuse-related problems. JRA offers a continuum of chemical dependency treatment services within its facilities. All services are certified by the Division of Alcohol and Substance Abuse (DASA). Approximately 96 youths are served each month, receiving inpatient, intensive outpatient, outpatient, and day treatment.

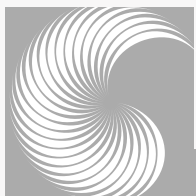
In State Fiscal Year 2003, 568 Youths Who Committed Offenses Received Treatment Under the Chemical Dependency Disposition Alternative.



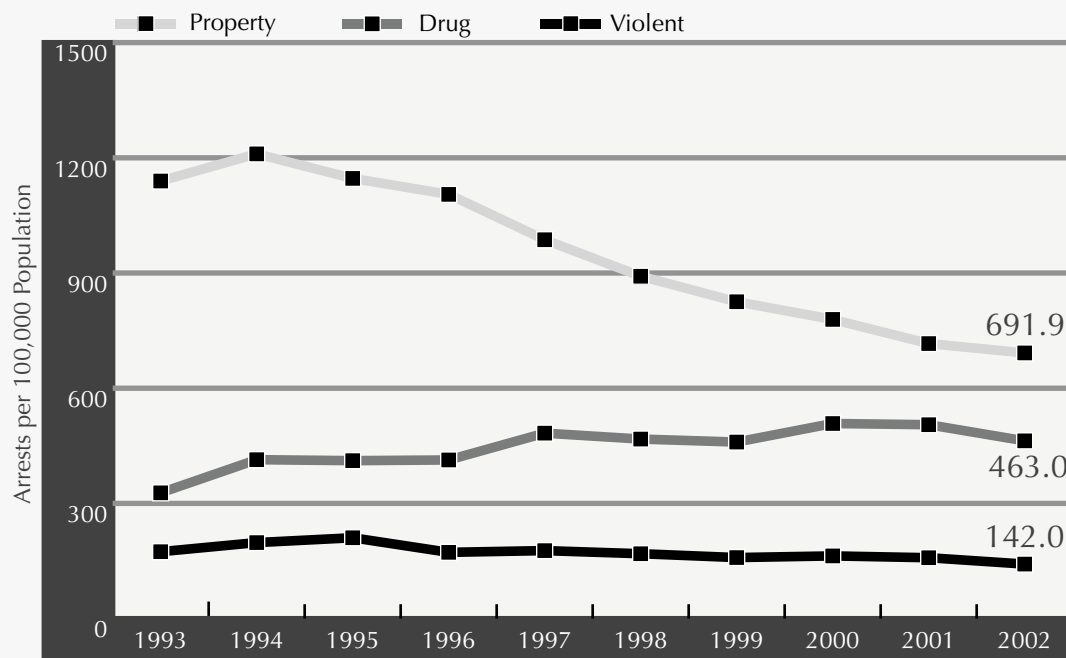
Source: Client Tracking System, Juvenile Rehabilitation Administration, Washington State Department of Social and Health Services.

In 1998, the Legislature created the Chemical Dependency Disposition Alternative (CDDA). Under CDDA, juvenile courts may sentence chemically abusing and dependent youth to treatment rather than confinement. CDDA represents a collaboration between the Juvenile Rehabilitation Administration, Division of Alcohol and Substance Abuse, Medical Assistance Administration, local juvenile courts, University of Washington, and county alcohol/drug coordinators. A 2004 report to the Legislature prepared by the Alcohol and Drug Abuse Institute, University of Washington, found that committable youth completing CDDA incurred fewer convictions; were less likely to be detained; were more likely to be enrolled in school; were more likely to be working full-time; reported better family and social relationships; and reported fewer emotional difficulties.¹

¹ Rutherford, M., et al., *Report to the Legislature: Chemical Dependency Disposition Alternative*. Olympia, WA: Washington State Department of Social and Health Services, Juvenile Rehabilitation Administration, 2004.



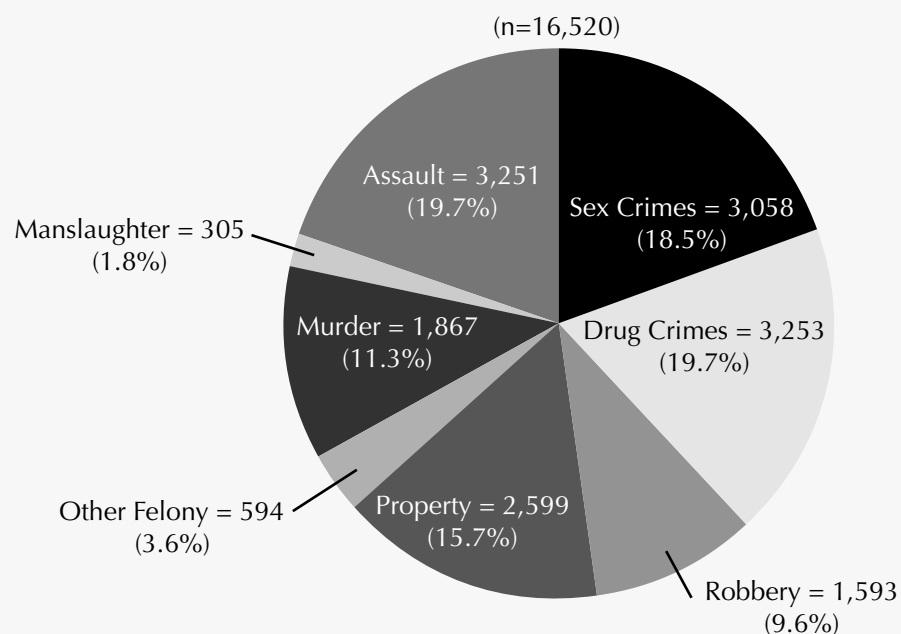
While Arrest Rates for Violent and Property Offenses in Washington State Have Declined, the Arrest Rate for Drug Abuse Violations Has Increased Significantly Since 1993.



Source: Washington Association of Sheriffs and Police Chiefs, *Crime in Washington* annual reports; data adjusted by the Washington State Caseload Forecast Council.

Combined juvenile/adult arrests drug offenses have climbed from 17,248 in 1993 to 27,975 in 2002. However, the number of arrests in all three categories – property, drug, and violent – declined in 2002. Over the past decade, arrests for property crime have dropped precipitously, while arrests for violent crime have declined slowly. Arrest data may reflect a jurisdiction's final resources, enforcement policy, and officer discretion, as well as the actual level of drug-related or other criminal activity.

More Inmates in Department of Corrections Custody are Convicted of Drug Offenses than Any Other Class of Crime.

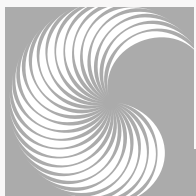


Source: Planning and Research Section, Washington State Department of Corrections, *Client Characteristics, Population Movement, and Custody: April 2003 – March 2004*.

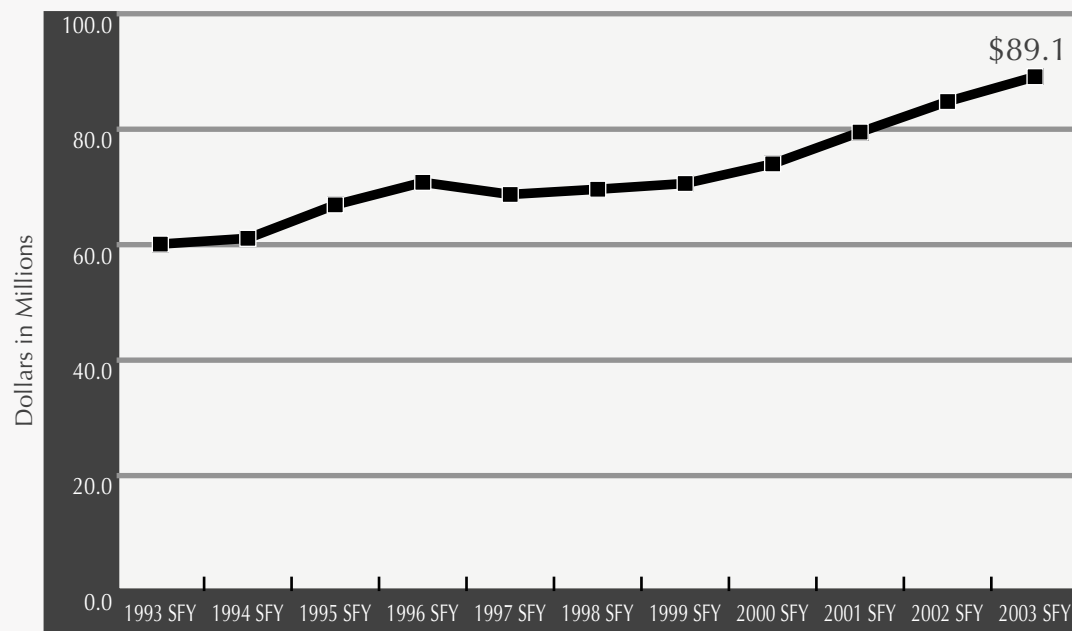
Almost one in five inmates in the custody of the Department of Corrections – in prisons, pre-release facilities, and work release – were convicted of drug offenses, making drug crimes the largest category of offenses. Between 60-80% of inmates are estimated to be in need of chemical dependency treatment.¹ More than half of males arrested for violent offenses in King and Spokane Counties in 2000 tested positive for illegal drugs.²

¹ Washington State Department of Corrections, January 2002.

² Office of Justice Programs, *Arrestee Drug Abuse Monitoring Program 2000 Annualized Site Reports*. Washington, DC: U.S. Department of Justice, National Institute of Justice, 2001.



The Costs of Imprisoning Drug Offenders in Washington State Continue to Rise.*



Source: Washington State Department of Corrections; Office of Program Research, Washington State House of Representatives.

Costs for imprisoning felony drug offenders in Washington State have grown faster than those for imprisoning other types of offenders. The number of imprisoned drug offenders has increased from 1,822 in SFY 1991 to 3,348 in SFY 2003. New sentencing initiatives are now diverting a larger portion of drug offenders into chemical dependency treatment.

**Operating expenses only; excludes capital and supervision costs.*

The Problem: Substance Abuse Prevalence & Trends

**AREAS OF
SUBSTANCE
ABUSE
IMPACT**

Birth Defects/
Complications

Accident
Risks

Health
Consequences

Infectious
Diseases

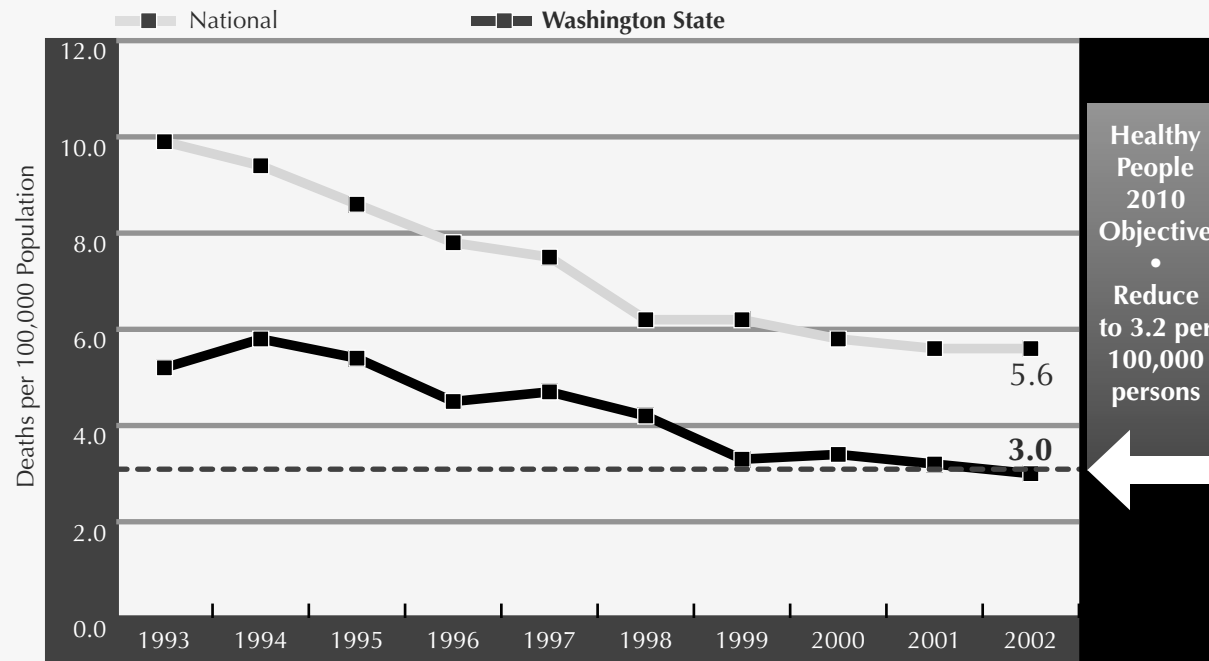
Crime

Violence

Family
Distress



The Homicide Rate in Washington State Continues to Decline.



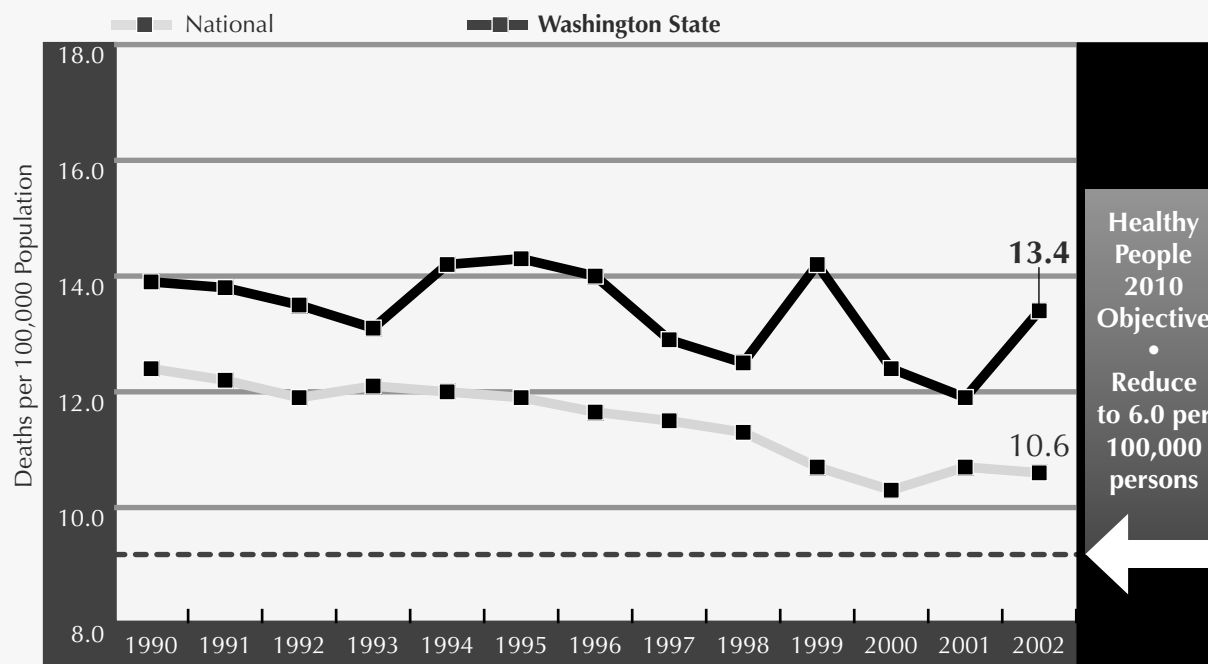
Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports. State data from the Washington Association of Sheriffs and Police Chiefs, *Crime in Washington State* annual reports.

There were 184 homicides in Washington State in 2002. Of these, nine were drug-related, and 15 occurred as a result of brawls while under the influence of alcohol. It is unknown how many of the 72 homicides listed as “other”, including those related to child abuse and domestic violence, were associated with alcohol and other drug use.¹

This graph indicates that Washington State’s homicide rate has been lower than the national rate for more than a decade, has dropped significantly since 1995, and is now lower than the *Healthy People 2010* objective.

¹ Washington Association of Sheriffs & Police Chiefs, *Crime in Washington State 2003 Annual Report*. Olympia, WA: 2003.

The Suicide Rate in Washington State is Consistently Higher than the Nation.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Alcohol and drug abuse are closely associated with the risk of suicide. A 1997 study found that use of alcohol almost doubles the risk of suicide in the home, while use of illegal drugs is associated with a seven-fold increase in risk.¹ However, the actual role of alcohol and other drugs in suicide is not clear. Some researchers see alcohol/drug involvement as self-medication to relieve depression or other psychological problems that eventually lead to suicide.² Others suggest that they loosen inhibitions or impair psychological and cognitive process that normally constrain people from suicide.³ Another perspective is that alcohol/drug use is part of the social disintegration that accompanies suicide.⁴

Washington State has a consistently higher suicide rate than the nation. Suicide remains the second leading cause of death among young people ages 15-24 in Washington.

¹ Rivara, F. et al. "Alcohol and Illicit Drug Abuse and the Risk of Violent Death in the Home," *Journal of the American Medical Association* 278(7), 1997.

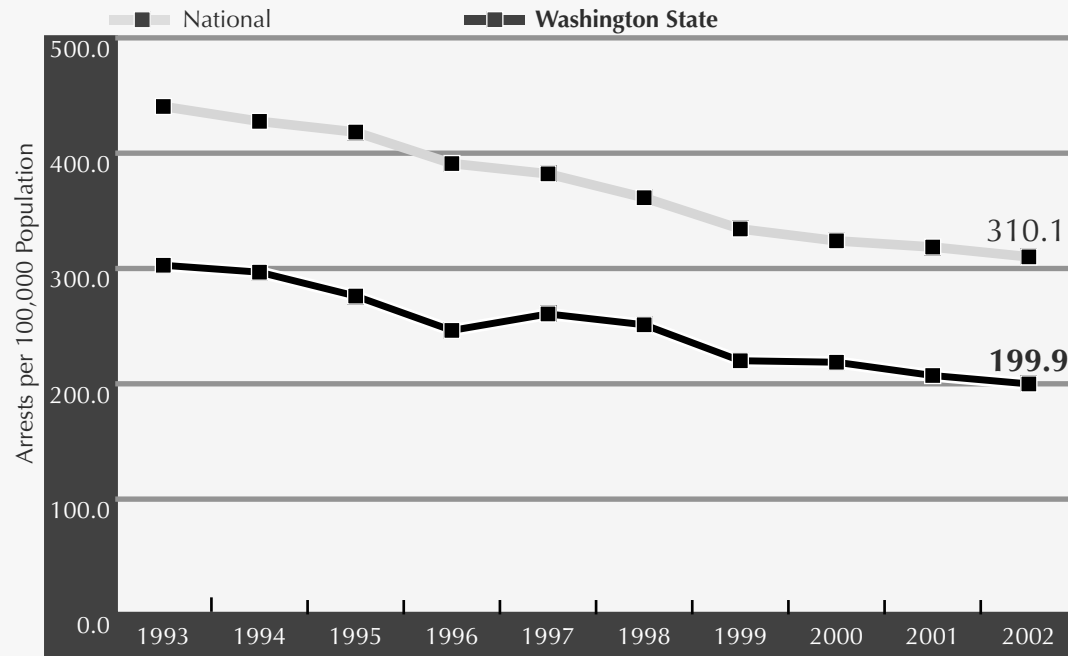
² Shaffer, D. "Suicide: Risk Factors and the Public Health," *American Journal of Public Health* 83, 1993.

³ Zeichner, A. et al. "Alcohol and Aggression: Effects of Personal Threat on Human Aggression and Affective Arousal," *Alcoholism: Clinical and Experimental Research* 18, 1994.

⁴ Yang, B. "The Economy and Suicide," *American Journal of Economics and Sociology* 51, 1992.



The Rate of Aggravated Assault in Washington State Remains Well Below the National Rate, and Continues to Decline.



Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports. State data from Washington Association of Sheriffs & Police Chiefs, *Crime in Washington State* annual reports.

The federal Uniform Crime Reporting Program defines an aggravated assault as the unlawful attack by one person on another for the purpose of inflicting or aggravating bodily injury. An assault of this type is usually accompanied by the use of a weapon, or by means likely to produce death or severe harm.

This graph indicates that Washington State has a consistently lower rate of aggravated assaults than the nation. The rate has declined 34.0% since 1993.

Washington State Consistently Has a Lower Rate of Violent Crime than the Nation.



Source: National and state data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports.

This graph indicates that Washington State has had a consistently lower incidence of violent crime than the nation for more than a decade. Violent crime rates are falling, both in the state and the nation. The Arrestee Drug Abuse Monitoring Program found that in 2001, 63.6% of males arrested for violent offenses in King County and 61.6% of males arrested for violent offenses in Spokane County tested positive for illegal drugs.¹

The most serious felony crimes against persons comprise the violent crime index. These offenses include murder and non-negligent manslaughter, forcible rape, robbery, and aggravated assault. All violent crimes involve force or the threat of force. This index is based upon offenses that become known to police, regardless of whether or not an arrest occurs.

¹ Arrestee Drug Abuse Monitoring Program, Office of Justice Programs, National Institute of Justice. *Drug Use and Related Matters Among Adult Arrestees, 2001*. Washington, DC: U.S. Department of Justice, 2002.

The Problem: Substance Abuse Prevalence & Trends

**AREAS OF
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IMPACT**

Birth Defects/
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Accident
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Diseases

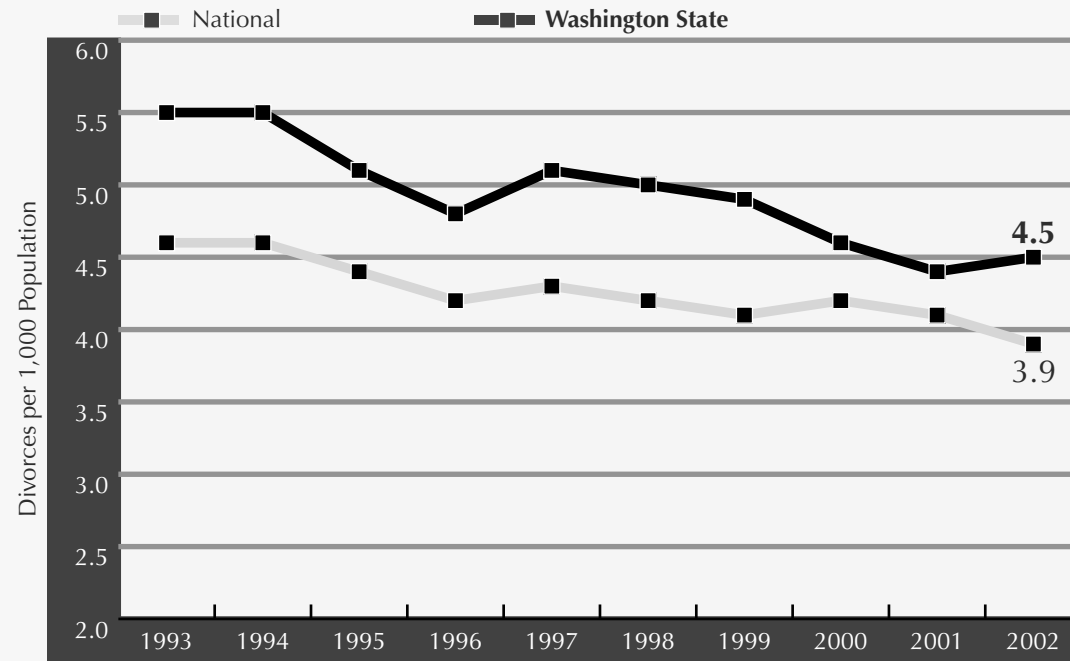
Crime

Violence

Family
Distress



The Divorce Rate in Washington State Has Declined Over the Past Decade.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

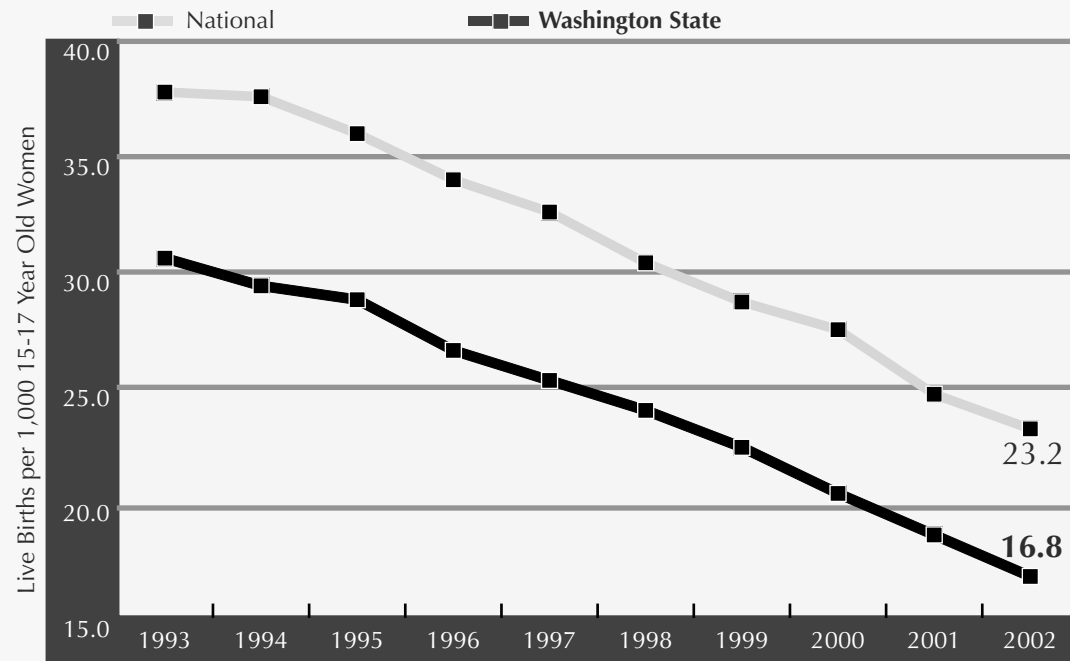
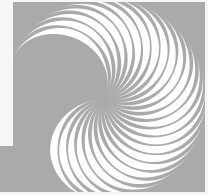
Studies indicate that children from homes broken by marital discord are at a higher risk of drug use.¹

This graph indicates that couples in Washington State experience more divorces (including annulments) than couples nationally. In 2002, at least 51.5% of the 27,205 divorces in Washington State involved families with children.² Caution must be exercised in interpreting divorce rates, as they are computed based on the total population, rather than upon the number of individuals actually married.

¹ Kabel, J. et al., *Profile on Risk and Protection for Substance Abuse Planning in Washington State*. Olympia, WA: Department of Social and Health Services, Division of Alcohol and Substance Abuse and Research and Data Analysis, 1997.

² Washington State Department of Health, Center for Health Statistics, 2003.

The Birth Rate Among Teens Ages 15-17 in Washington State and Nationally is in Steep Decline.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Teen pregnancy has long been associated with alcohol and other drug use. In a survey of women in Washington State who were 18 years old or younger at the time of their first pregnancy, almost one quarter reported having used alcohol or another drug when they first became pregnant, and 36% reported that their partner used alcohol or drugs at that time.¹ Alcohol and drug use in pregnancy is closely associated with a range of health effects among children, including Fetal Alcohol Syndrome and mental retardation. Maternal age is also a significant risk factor for infant mortality.²

This graph indicates that the rate of births per thousand among teens ages 15-17 is lower in Washington State than the nation, and continues to fall. In 2002, births to women under age 18 represented 2.8% of all births in Washington State.³

¹ Boer, D., & Fine, D., "Sexual Abuse as a Factor in Adolescent Pregnancy and Child Maltreatment," *Family Planning Perspectives* 241(1), 1992, 4-12.

² U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 16-3. Washington, DC: 2000.

³ Washington State Department of Health, Center for Health Statistics, 2003.

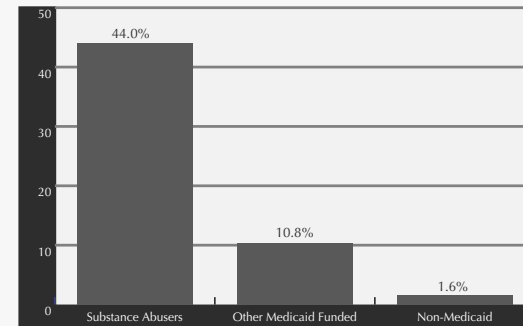


Infants Born to Low-Income Substance-Abusing Women Account for a Disproportionate Share of Child Protective Service (CPS) Referrals and Out-of-Home Placements.

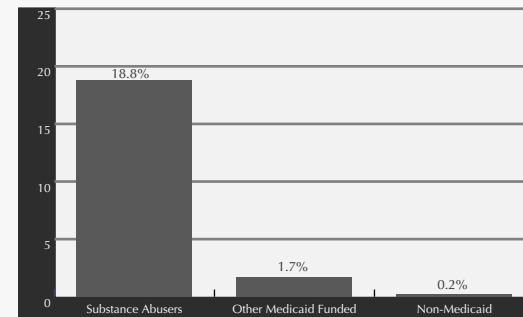
44% of Infants Born to Substance-Abusing Women Were Reported at “High Risk” of Imminent Harm.

18% of Infants Born to Substance-Abusing Women Were Placed Out of Home.

Percentage of Accepted CPS Referrals



Percentage of Out-of-Home Placements



Source: Cawthon, L., & Schrager. First Steps Database: Substance Abuse, Treatment, and Birth Outcomes. Office of Research and Data Analysis, Washington State Department of Social and Health Services, 1995.

Researchers have consistently found an association between alcohol and other drug abuse and virtually all forms of interpersonal violence, including child abuse and neglect. The 2001 Child Maltreatment Report from the National Clearinghouse on Child Abuse and Neglect Information found 903,000 substantiated claims of child maltreatment nationwide. The majority of these reports came from professional sources: legal, medical, social service, and educational professionals. Some 57% of reports were for neglect; 19% for physical abuse; 10% for sexual abuse; and 7% for psychological abuse. Children birth to age 3 accounted for 28% of substantiated reports.¹

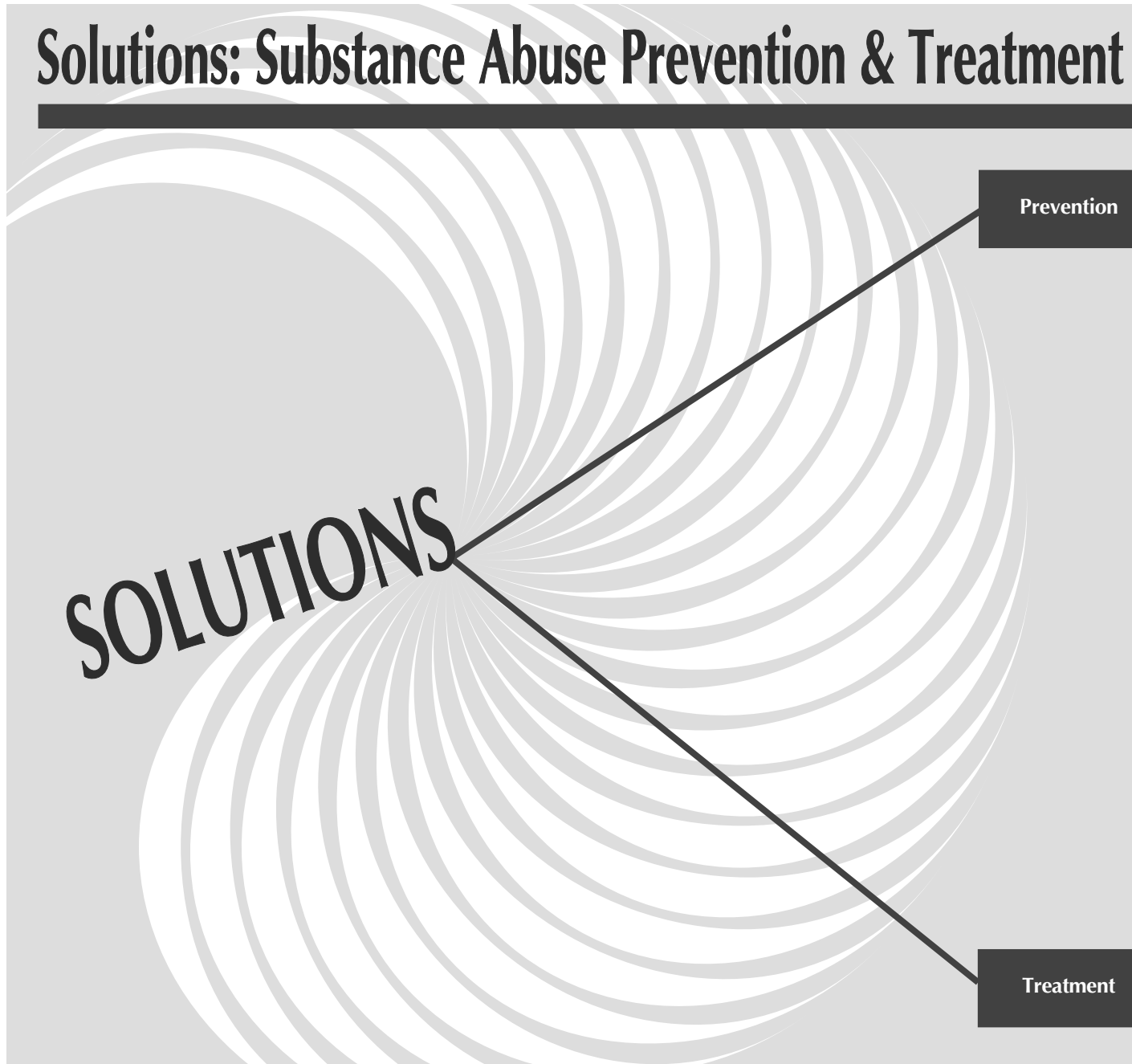
¹ McDonald, W., et al., *Child Maltreatment 2001*. Washington, DC: National Clearinghouse on Child Abuse and Neglect Information, Children's Bureau, Administration for Children and Family Services, U.S. Department of Health and Human Services, 2003.

Solutions: Substance Abuse Prevention & Treatment

SOLUTIONS

Prevention

Treatment





Introduction

State Law RCW 70.96A identifies the Division of Alcohol and Substance Abuse (DASA) as the “single state” agency for planning and delivery of substance abuse treatment and prevention services. All public substance abuse services funded by state or federal funds are either managed by DASA or operate in coordination with DASA (for example, services provided by the Department of Health, the Department of Licensing, the Department of Corrections, and the Office of the Superintendent of Public Instruction).

DASA does not provide direct prevention or treatment services, but rather, provides these services through contracts with county governments, Indian tribes, and non-profit service providers. The largest portion of available federal and state funds are contracted through county and tribal governments. Each biennium, DASA develops a plan for program development and prevention and treatment service strategies.

County governments and tribes are awarded prevention and treatment funds on the basis of a formula established by DASA in coordination with these governmental units. Counties and tribes are expected to conduct a needs assessment for prevention and treatment needs, based on the available funding and submit a plan to DASA. Contracts for community-based prevention and treatment services are written to include work statements specifying the activities which will be provided under the contracts.

Solutions: Substance Abuse Prevention & Treatment

SOLUTIONS

Prevention

Treatment



Prevention

Washington's youth are faced with choices every day that may result in a variety of problem behaviors. Among the most dangerous of those behaviors is the abuse of alcohol, tobacco, and other drugs. It is the Division of Alcohol and Substance Abuse's (DASA) policy that any use of illicit drugs and the inappropriate use of legal drugs, including alcohol, are considered drug abuse. DASA's goal for the majority of prevention programs it supports is two-fold: programs should act to *delay* the onset of alcohol and tobacco use, and also act to *prevent* the abuse of alcohol, tobacco, and other drugs.

DASA contracts with counties and tribes to provide services at the community level. The Risk and Protective Factor Framework is the cornerstone of all program investments.

Risk and Protective Factor Framework

Over the past two decades, much research has focused on determining how drug abuse begins and how it progresses. Just as medical researchers have found risk factors for heart disease (e.g., lack of exercise, smoking), prevention research has identified a set of risk factors and protective factors related to drug abuse. The more risk factors a child is exposed to, the more likely the child will abuse drugs, alcohol, or tobacco. Some risk factors may be more powerful than others at certain stages in development, such as peer pressure during the teenage years. At each stage, risks occur that can be changed through prevention intervention. Early childhood risks, such as aggressive behavior, can be changed or prevented with family, school, and community interventions that focus on helping children develop appropriate, positive behaviors. If not addressed, negative behaviors can lead to more risks, such as academic failure and social difficulties, which, in turn, put children at further risk for drug abuse later in life.

Not every young person who is exposed to multiple risks becomes a substance abuser, juvenile delinquent, school dropout, or teen parent. There are conditions – known as protective factors – that can counter the risks. Protective factors are buffers in the lives of young people that either reduce the impact of the risk or change the way a person responds to the risk. A strong parent-child bond is an example of a primary protective factor. When children are strongly attached to positive families, friends, schools, and communities, they are more likely to be committed to achieving the goals valued by these groups and are less likely to develop problems as a teenager.

Risk and protective factor-focused prevention programs are based on a simple premise: to prevent a substance abuse problem, we must identify those factors that increase the likelihood of that problem developing and then intervene in ways that reduces the risk. At the same time, we must identify protective factors that buffer individuals from the risks present in their environments and then find ways to strengthen the protection.¹

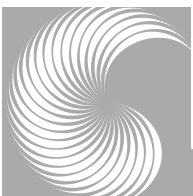
Many risk factors associated with adolescent substance abuse are also tied to other problem behaviors, including: delinquency, teen pregnancy, school dropout, violence, and depression/anxiety. While the primary focus of prevention programs supported by DASA is substance abuse, addressing its risk factors will likely impact multiple problem behaviors.



Risk and protective factors fall into four domains. Research indicates that by reducing risk factors and enhancing protective factors in each of the domains, the likelihood that youth will engage or experience problem behaviors can be substantially reduced.

The four domains are:

- Community
- Family
- School
- Individual/Peer



Risk Factors and Adolescent Problem Behavior

RISK FACTORS BY DOMAIN

	Substance Abuse	Delinquency	Teen Pregnancy	School Dropout	Violence	Depression/Anxiety
Community						
Availability of Drugs	■				■	
Community Laws and Norms Favorable Toward Drug Use, Firearms, and Crime	■	■			■	
Transitions and Mobility	■	■		■		■
Low Neighborhood Attachment and Community Disorganization	■	■			■	
Extreme Economic Deprivation	■	■	■	■	■	
Family						
Family History of the Problem Behavior	■	■	■	■	■	■
Family Management Problems	■	■	■	■	■	■
Family Conflict	■	■	■	■	■	■
Favorable Parental Attitudes and Involvement in the Problem Behavior	■	■			■	
School						
Academic Failure Beginning in Late Elementary School	■	■	■	■	■	■
Lack of Commitment to School	■	■	■	■	■	
Individual/Peer						
Early and Persistent Antisocial Behavior	■	■	■	■	■	■
Rebelliousness	■	■		■		
Friends Who Engage in the Problem Behavior	■	■	■	■	■	
Favorable Attitudes Toward the Problem Behavior	■	■	■	■		
Early Initiation of the Problem Behavior	■	■	■	■	■	
Constitutional Factors	■	■			■	■
Gang Involvement	■	■			■	

Source: Social Development Research Group, University of Washington.



Prevention Works!

In 2003, the Washington State Legislature requested the Washington State Institute for Public Policy to examine prevention and early intervention programs for youth. The purpose was to see whether there is credible scientific evidence to indicate that research-based prevention programs can produce benefits for communities that outweigh financial costs. Some 60 programs were evaluated. Their conclusion, published in a report to the Legislature in July 2004, was that certain well-chosen and well-implemented programs, including programs being used in Washington State, can achieve such benefits.¹ Several such programs are profiled on the following pages.

Principles of Effective Substance Abuse Prevention

In Washington State, the Division of Alcohol and Substance Abuse contracts with county prevention providers. Providers are required to use scientifically based best practices for at least 50% of programming. When choosing to design and implement other programs, providers are required to refer to the federal Center for Substance Abuse Prevention's *Principles of Substance Abuse Prevention* and apply the 78 scientifically defensible principles – which are divided by domain -- to their work in communities.²

The following pages provide examples of programs being implemented in Washington State that have been scientifically demonstrated to work.

Individual Domain

- Build social and personal skills.
- Design culturally sensitive interventions.
- Cite immediate consequences.
- Combine information dissemination and media campaigns with other interventions.
- Provide positive alternatives to help youth in high-risk environments develop personal and social skills in a natural and effective way.
- Recognize that relationships exist between substance use and a variety of other adolescent health problems.
- Incorporate problem identification and referral into prevention programming.
- Provide transportation to prevention programs.

¹ Aos, S., et al., *Benefits and Costs of Prevention and Early Intervention Programs for Youth*. Olympia, WA: Washington State Institute for Public Policy, 2004.

² Center for Substance Abuse Prevention, *Principles of Substance Abuse Prevention*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, Division of Knowledge Development and Education, 2001. Detailed descriptions of each principle can be found at: www.samhsa.gov/centers/csap/modelprograms/pdfs/pubs_Principles.pdf

**Family Domain**

- Target the entire family.
- Help develop bonds among parents in programs; provide meals, transportation, and small gifts; sponsor family outings; and ensure cultural sensitivity.
- Help minority families respond to cultural and racial issues.
- Develop parenting skills.
- Emphasize family bonding.
- Offer sessions where parents and youth learn and practice skills.
- Train parents to both listen and interact.
- Train parents to use positive and consistent discipline techniques.
- Promote new skills in family communication through interactive techniques.
- Employ strategies to overcome parental resistance to family-based programs.
- Improve parenting skills and child behavior with intensive support.
- Improve family functioning through family therapy when indicated.
- Explore alternative community sponsors and sites for schools.
- Videotape training and education.

Peer Domain

- Structure alternative activities and supervise alternative events.
- Incorporate social and personal skill-building opportunities.
- Design intensive alternative programs that include a variety of approaches and substantial time commitment.
- Communicate peer norms against use of alcohol and illicit drugs.
- Involve youth in the development of alternative programs.
- Involve youth in peer-led interventions, or interventions with peer-led components.
- Counter the effects of deviant norms and behaviors by creating an environment for youth with behavior problems to interact with other nonproblematic youth.



School Domain

- Avoid relying solely on knowledge-oriented interventions designed to supply information about negative consequences.
- Correct misconceptions about the prevalence of use in conjunction with other education approaches.
- Involve youth in peer-led interventions or interventions with peer-led components.
- Give students opportunities to practice newly acquired skills through interactive approaches.
- Help youth retain skills through booster sessions.
- Involve parents in school-based approaches.
- Communicate a commitment to substance abuse prevention in school policies.

Community Domain

- Develop integrated, comprehensive prevention strategies rather than one-time community-based events.
- Control the environment around schools and other areas where youth gather.
- Provide structured time with adults through mentoring.
- Increase positive attitudes through community service.
- Achieve greater results with highly involved mentors.
- Emphasize the costs to employers of workers' substance use and abuse.
- Communicate a clear company policy on substance abuse.
- Include representatives from every organization that plays a role in fulfilling coalition objectives.
- Retain active coalition members by providing meaningful rewards.
- Define specific goals and assign specific responsibility for their achievement to subcommittees and task forces.
- Ensure planning and clear understanding for coalition effectiveness.
- Set outcome-based objectives.
- Support a large number of prevention activities.
- Organize at the neighborhood level.
- Assess progress from an outcome-based perspective and make adjustments to the plan of action to meet goals.
- Involve paid coalition staff as resource providers and facilitators rather than as direct community organizers.



Society/Environmental Domain

- Develop community awareness and media efforts.
- Use mass media appropriately.
- Provide structured time with adults through mentoring.
- Avoid the use of authority figures.
- Broadcast messages frequently over an extended period of time.
- Broadcast messages through multiple channels when the target audience is likely to be viewing or listening.
- Disseminate information about the hazards of a product or industry that promotes it.
- Promote replacement of more conspicuous labels.
- Promote restrictions on tobacco use in public places and private workplaces.
- Promote clean indoor air laws.
- Combine beverage server training with law enforcement.
- Combine beverage servers' legal liability with laws against service to intoxicated patrons and against sales to minors.
- Increase the price of alcohol and tobacco through excise taxes.
- Increase minimum purchase age for alcohol to 21.
- Limit the location and density of retail alcohol outlets.
- Employ neighborhood anti-drug strategies.
- Enforce minimum purchase age laws using undercover buying operations.
- Use community groups to provide positive and negative feedback to merchants.
- Employ more frequent enforcement operations.
- Implement "use and lose" laws.
- Enact deterrence laws and policies for impaired driving.
- Enforce impaired-driving laws.
- Combine sobriety checkpoints with positive passive breath sensors.
- Revoke licenses for impaired driving.
- Immobilize or impound vehicles of those convicted of impaired driving.
- Target underage drivers.



Prevention Works!

Prevention programs address risk and protective factors in four domains. Research indicates that by reducing risk factors and enhancing protective factors in each of the domains, the likelihood that youth will engage or experience problem behaviors can be substantially reduced. Below are descriptions of programming in each domain, and a description of programs being utilized in each domain among Washington's counties and tribes.

Community Domain Programming

In community domain programming, anti-drug norms and pro-social behaviors are strengthened through the involvement of civic, religious, law enforcement, and other government organizations. Many programs coordinate prevention efforts to communicate consistent messages through school, work, religious institutions, and the media. Research has shown that programs that reach youth through multiple settings can strongly impact community norms. Community-based programs may also include policy development, law enforcement, mass media efforts, and community-wide awareness efforts. Some carefully structured and targeted media interventions have proven to be very effective in reducing drug abuse.

To determine the level of risk/protective factors in the community domain, both archival and data from the Adolescent Health Behavior Survey are utilized. Archival indicators include: number of alcohol sales outlets and tobacco distributors; number of children in families receiving some form of public assistance; population not voting in elections; and net migration. Survey indicators include: perceived availability of drugs; laws and norms favorable to drug use; personal transitions and mobility; and opportunities and rewards for pro-social involvement.

The following community evidence-based programs and strategies are being implemented in Washington counties and tribes in the 2003-2005 Biennium:

Communities that Care® (CTC) provides research-based tools to guide communities through a process leading to a place to promote the positive development of children and youth, and prevent adolescent problem behaviors that impede positive development. Implemented in Cowlitz and Snohomish Counties.

Community Trials Intervention to Reduce High-Risk Drinking is a multi-component program developed to alter alcohol use patterns of people of all ages, to combat drinking and driving, underage drinking, binge drinking, and related problems. Implemented in Kittitas County.

Counter-Advertising uses the media to promote negative images about tobacco use, reveal the number of teens who actually use tobacco, and emphasize the unacceptability of tobacco use. It counters tobacco industry advertising that links tobacco use with peer acceptance, success, and good times. Implemented in Whitman County.

Project Northland consists of social-behavioral curricula in schools, peer leadership training among youth to increase peer pressure resistance and social competence skills, parental involvement/education to provide parental support and modeling, and community-wide taskforce activities aimed at changing the larger environment. Implemented in Mason County.



Retail-Directed Interventions include merchant and community education about adolescent tobacco use and laws prohibiting tobacco sales to minors, and enactment and enforcement of laws prohibiting tobacco sales to minors. Implement in Grays Harbor and Kitsap Counties.

Tobacco-Free Environmental Policies are directed at creating environments where youth are not exposed to the possession and use of tobacco. Activities include: reviewing existing laws and compliance with laws restricting tobacco use; reviewing the effects of anti-smoking school policies on adolescent smoking; providing technical assistance and guidance on developing and implementing tobacco-free policies and environments.



Family Domain Programming

Risk factors are reduced among young children by teaching parents better family management practices, such as communication skills, appropriate discipline styles, and firm and consistent rule enforcement. Research confirms the benefits of parents providing consistent rules and discipline, talking to children about drugs, monitoring their activities, getting to know their friends, understanding their problems and concerns, and being involved in their learning. The importance of the parent-child relationship continues through adolescence.

Archival indicators are used to determine the level of risk/protective factors in the family domain. These include: divorce rates; domestic violence arrests; percentage of adults in chemical dependency treatment programs; alcohol- and drug-related deaths; percentage of children living in foster care or away from home; number of victims in accepted referrals to Child Protective Services.

The following community evidence-based programs and strategies are being implemented in Washington counties and tribes in the 2003-2005 Biennium:

Creating Lasting Family Connections assists high-risk youth ages 11 to 15 and their families to become strong, healthy, and mutually supportive. The program provides parents and youth with defenses against environmental risk factors by teaching appropriate skills for personal growth, family enhancement, and interpersonal communication, including refusal skills for both parents and youth. Implemented in King County.

Families in Action is a program aimed at families in rural school districts with students entering middle or junior high school. Implemented in Skamania County.

Guiding Good Choices® (formerly known as Preparing for the Drug-Free Years) is a multi-media program that provides parents of children in 4th through 8th grades the knowledge and skills necessary to guide their children through early adolescence. The program aims to strength and clarify family expectations for behavior, enhance the conditions that promote bonding in the family, and teach skills to parents and children to successfully meet the expectations of their family and resist alcohol, drug, and tobacco use. Implemented in Benton/Franklin, King, and Yakima Counties.

Home Visiting provides a bridge between a parent with a young child and the outside world by way of a visitor who cares about the raising of children. The visitor may provide information and/or emotional support. Visitors may be trained in health (e.g. nurses), human development (psychologists or social works), cognitive and social skills instruction (preschool teachers), or some combination (paraprofessionals). Implemented in Clallam County.

Incredible Years helps parents improve communication skills with their children, enhance limit-setting skills by means of nonviolent discipline techniques, develop their own problem-solving skills, and learn effective methods of anger management. Implemented in Clallam and Yakima Counties.



NICASA Parenting Project is implemented in the workplace and enriches family relationships and promotes healthy environments that build resistance to social and personal dysfunction. It focuses on the need to establish supportive networks among working parents, improve parent/child relationships, increase ability to balance work and family life, enhance the corporate climate for workers, and improve parenting skills. Implemented in Clark County.

Nurturing Programs are family-centered and build nurturing skills as alternatives to abusive childrearing attitudes and practices. Implemented in Ferry, King, Lewis, Spokane, and Whitman Counties.

Parenting Skills Programs teach communication and child management skills in order to improve parent-child relationships and foster good psychosocial adjustment in children. Implemented in King County.

Parenting Wisely is an interactive CD-ROM-based program designed for at-risk families with children from early elementary to high school age. This format overcomes illiteracy barriers, thereby meeting the needs of families who do not usually attend or finish parenting education. It seeks to help families enhance relationships and decrease conflict through behavior management and support, and builds confidence in parenting skills. This program has been presented in Spanish, as well as English. Implemented in Thurston County.

Parent and Family Skills Programs enable families to better nurture and protect their children, help children develop prosocial behaviors, and train families to deal with particularly challenging children. Implemented in Kitsap County.

Parents as Teachers is an early childhood parent education and support program serving families from pregnancy through kindergarten. The program provides: 1) personal visits – certified parent educators help parents understand and have appropriate expectations for each stage of their child's development; 2) group meetings – parents meet to enhance their parenting knowledge, gain new insights and share their experiences, common concerns, and successes; 3) developmental screenings – periodic screening of overall development, health, hearing, and vision to provide early detection of potential problems and prevent later difficulties in school; and 4) linkage to a resource network – families are assisted in accessing other needed community services. Implemented in Garfield County.

Parents Who Care is a skill-building program created for families with children between ages 12-16. It is grounded in the social development model, emphasizing that young people should experience opportunities for active involvement in family, school, and community, develop skills for success, and be given recognition and reinforcement for positive effort and improvement. It focuses on strengthening family bonds and establishing clear standards for behavior, helping parents more appropriately manage their teenager's behavior while encouraging their adolescent growth toward independence. Implemented in Clallam and Okanogan Counties.



Storytelling for Empowerment is based on the understanding that storytelling has been used for centuries by humans to pass on values and cultural identity, and as such is a natural vehicle for nurturing resiliency factors in youth. This approach enhances the buffering effects of a positive peer group and a positive cultural identity. It is designed for club and classroom settings serving American Indian and Latino-Latina middle school youth. The program addresses the confusion of cultural identity, the lack of congruence of multicultural learning styles and instruction, and the lack of consistent, positive parental role models. Implemented in King County.

Strengthening Families Program involves elementary school children ages 6-12 and their families in family skills training sessions. It uses family systems and cognitive/behavioral approaches to increase resiliency and reduce risk factors for behavioral, emotional, academic, and social problems. It builds on protective factors by improving family relationships, enhancing parenting skills, and increasing the youth's social and life skills. Implemented in Cowlitz, Garfield, Grant, Grays Harbor, Mason, Pend Oreille, Skagit, Thurston, and Wahkiakum Counties.

Strengthening Families Program: For Parents and Youth 10-14 resulted from an adaptation of the Strengthening Families Program (SFP). It focuses on improving parental skills in nurturing and child management, and enhancing interpersonal and personal competencies and pro-social skills among youth. Videotapes portraying pro-social behaviors are utilized and are appropriate for multi-ethnic families. This program has been presented in English and Spanish. Implemented in Adams, Asotin, Benton/Franklin, Chelan/Douglas, Columbia, Ferry, Island, King, Lewis, Lincoln, Okanogan, San Juan, Skagit, Spokane, Stevens, Wahkiakum, Whatcom, and Yakima Counties, and the Spokane Tribe.

Strengthening Multi-Ethnic Families and Communities targets ethnic minority parents of children aged 3-18 years who are interested in raising children with a commitment to leading a violence-free, healthy lifestyle. Short-term objectives are to increase parents' sense of competence, positive family/parent/child interactions and relationships, child self-esteem and self-discipline, child social competency skills, and increased parental involvement in churches, schools, community agencies, and other locations. Implemented in King, Pierce, and Snohomish Counties.



School Domain Programming

School domain programming focuses on the social and academic skills of children, including peer relationships, self-control, coping, and drug-refusal skills. School-based prevention programs are most successful when integrated into the academic program, because school failure is strongly associated with drug abuse. Integrated programs strengthen the student-school bond and reduce the likelihood of dropping out. Other types of interventions include school-wide programs that affect the school environment as a whole. All of these activities can serve to strengthen protective factors against drug abuse.

Both archival and Adolescent Health Behavior Survey data are used to determine the risk/protective factors in this domain. Archival data include: high school dropout rates; academic failure; and poor academic performance in grades 4 and 8. Survey data include: commitment to school; and opportunities for pro-social involvement.

The following community evidence-based programs and strategies are being implemented in Washington counties and tribes in the 2003-2005 Biennium:

Tutoring Programs improve academic success among elementary school children who have serious academic problems in reading and/or mathematics. Initial tutoring sessions involve an assessment of the child's successes and failures in regular classroom reading material. Tutors are trained in the use of behavior techniques to help children attempt tasks they would otherwise avoid. Implemented in Kitsap and Pierce Counties.

Across Ages is a school- and community-based program for youth ages 9 to 13 that seeks to strengthen the bonds between adults and youth, and provide opportunities for positive community involvement. A unique feature of Across Ages is the pairing of older adult mentors (age 55 and above) with young adolescents, specifically youth making the transition to middle school. The program employs mentoring, community service, social competence training, and family activities to build youths' sense of personal responsibility for self and community. Implemented in Benton/Franklin Counties.

PAL® Peer Assistance and Leadership Programs are driven by needs assessment and include the following: group and one-to-one peer tutoring and mentoring; activities and group discussions on issues such as alcohol and substance use, and career choices; peer mediation and conflict resolution services; and participation in community service projects. The programs seek to develop communication, decision-making, problem-solving, team and relationship-building, and refusal skills. Implemented in Pend Oreille and Walla Walla Counties.



Individual/Peer Domain Programming

In individual/peer domain programming is primary directed at enhancing protective factors. Positive bonding is one of the protective factors that can buffer a young person who is exposed to multiple risk factors. Bonding is most likely to occur when youth are given opportunities to contribute in a meaningful way to their community, family, peers, and/or school; are taught the skills necessary to be successful in that opportunity; and are recognized for their efforts. Individuals are also provided information about the negative consequences of risky behaviors, including substance abuse.

Both archival and Adolescent Health Behavior Survey data are utilized in determining the level of risk in the individual/peer domain. Archival data include: alcohol- and drug- related arrests, ages 10-14; property crime arrests, ages 10-14; vandalism arrests, ages 10-14. Survey data include: rebelliousness; antisocial behavior; friends' use of drugs; interaction with antisocial peers; favorable attitudes toward drug use and/or antisocial behavior; perceived risks of drug use; perceived rewards for antisocial behavior; and early initiation of problem behaviors.

The following community evidence-based programs and strategies are being implemented in Washington counties and tribes in the 2003-2005 Biennium:

All Stars comes in two formats: middle school classroom and community-based formats. Each reinforces the belief that risky behaviors are not normal or acceptable by the adolescent's peer group; cultivates the belief that risky behaviors do not fit with the youth's personal ideals and future aspirations; creates strong, voluntary personal and public commitments to not participate in risky behaviors; strengthens relationships between adolescents, social institutions, and significant adults; and helps parents listen to their children, communicate clear no-use expectations about alcohol and other drugs, and support their children in working toward positive life goals. Implemented in Ferry, Grant, King, and Pacific Counties.

Big Brothers/Big Sisters is a mentoring program that matches an adult volunteer with a child, with the expectation that a caring and supportive relationship will develop. A professional staff member selects, matches, monitors, and closes the relationship with the volunteer and child, and communicates with the volunteer, parent/guardian, and the child throughout the matched relationship. Implemented in Clark, Ferry, Island, Jefferson, King, Pierce, San Juan, Skamania, Snohomish, Spokane, and Whatcom Counties, and the Jamestown S'Klallam Tribe.

Brys Behavioral Monitoring and Reinforcement Program is a school-based, early intervention program based on behavior modification and teaching thinking skills. The program targets 7th and 8th graders and includes the following components: recording daily attendance and discipline referrals of program participants, weekly discussions with students in small groups about what to do to improve their teacher's impression of their behavior, and reared for every day that they come to school, arrive on time, and receive no disciplinary action. Implemented in Island and Spokane Counties.

Friendly PEERsuasion® is directed at girls of middle school age, ages 11-14, acquiring the knowledge, skills, and support systems to avoid substance abuse. Implemented in Walla Walla County.

LifeSkills®Training is a three-year prevention curriculum intended for middle school or junior high school students. It covers three major content areas: drug resistance skills and information, self-management skills, and general social skills.



Implemented in Chelan/Douglas, Ferry, Grant, King, Pend Oreille, Pierce, Skagit, Skamania, Snohomish, Walla Walla, Whitman, and Yakima Counties, and the Upper Skagit Tribe.

PATHS (Promoting Alternative Thinking Strategies) seeks to promote emotional and social competencies and reduce aggression and behavior problems in elementary school-aged children, while simultaneously enhancing the educational process in the classroom. Educators and counselors use it in classroom settings. Although it focuses primarily on the students, information and activities are included for use with parents. Implemented in Thurston County.

Positive Action aims to improve the academic achievement and behavior of children and adolescents. It is intensive, with lessons at each grade level from kindergarten through 12th grade that are reinforced all day, school-wide, at home, and in the community. Components can stand alone, and are useful in a variety of settings beyond the school. Implemented in Spokane County.

Project ALERT is a school-based, social resistance approach that specifically targets cigarettes, alcohol, and marijuana use. Implemented in Adams, Benton/Franklin, Garfield, Jefferson, King, Pacific, Pierce, and Whatcom Counties, and the Puyallup Tribe.

Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) provides a full range of substance use prevention and early intervention services. The program places highly trained professionals in schools to work with high-risk youth ages 14 to 18. Implemented in Kittitas and Klickitat Counties.

Project Towards No Drug Abuse provides detailed information to older teens about the social and health consequences of drug use. The program also provides instruction in active listening, effective communication skills, stress management, tobacco cessation techniques, and self-control. Implemented in Pierce County.

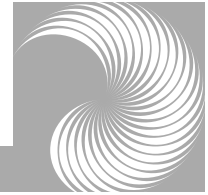
Second Step is a classroom-based social skills program for preschool through junior high students. It aims at reducing aggressive behaviors and increasing children's social-emotional competence. Implemented in Pend Oreille and Spokane Counties.

Sembrando Salud is a culturally sensitive anti-tobacco and alcohol use program specifically adapted for migrant Hispanic youth and their families. The program enhances parent-child communication skills as a way of improving and maintaining healthy youth decision-making. It utilizes a school and family curriculum delivered by bilingual/bicultural college students. Implemented in Skagit County.

SMART Leaders is a two-year booster program for youth who have completed "Stay SMART," a component of Boys & Girls Clubs of America's SMART Moves program. It reinforces the substance abuse prevention skills and knowledge of the first program, with sessions on self-concept, coping with stress, and resisting media pressures. Implemented in Jefferson and Whatcom Counties.

Keep A Clear Mind is a parent/child program for families with children in grades 4 through 6. This home-based program uses a correspondence format and consists of lessons on alcohol, tobacco, marijuana, and tools to avoid drugs. The overall goal is to increase parent/child communication, and to develop specific youth beliefs and skills to refuse and avoid "gateway" drug use. Implemented in Pacific, Stevens, and Walla Walla Counties.

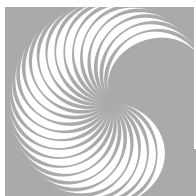
County Prioritized Risk Factors



The table below displays a summary of the prioritized risk factors for the 2003-2005 Biennium being addressed by each of the 39 counties in Washington State.

TARGETED RISK FACTORS	COUNTY	Adams	Asotin	Benton-Franklin	Chelan-Douglas	Clallam	Clark	Columbia	Cowlitz	Ferry	Garfield	Grant	Grays Harbor	Island	Jefferson	King	Kitsap	Kittitas	Klickitat	Lewis	Lincoln	Mason	Okanogan	Pacific	Pend Oreille	Pierce	San Juan	Skagit	Skamania	Snohomish	Spokane	Stevens	Thurston	Wahkiakum	Walla Walla	Whatcom	Whitman	Yakima	
Academic Failure Beginning in the Late Elementary School																																							
Availability of Alcohol/Drugs																																							
Community Laws and Norms																																							
Early + Persistent Antisocial Behavior																																							
Early Initiation of the Problem Behavior																																							
Extreme Economic Deprivation																																							
Family Conflict																																							
Family History of Problem Behavior																																							
Family Management Problems																																							
Favorable Attitudes Toward the Problem Behavior																																							
Favorable Parental Attitudes & Involvement in the Problem Behavior																																							
Friends Who Engage in the Problem Behavior																																							
Lack of Commitment to School																																							
Low Neighborhood Attachment & Community Disorganization																																							
Rebelliousness																																							
Transitions and Mobility																																							

Source: Data compiled from Division of Alcohol and Substance Abuse quarterly reports.



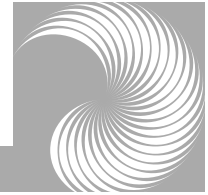
County Prioritized Protective Factors

The table below displays a summary of prioritized protective factors for the 2003-2005 Biennium being addressed by each of the 39 counties in Washington State.

TARGETED PROTECTIVE FACTORS ▼	COUNTY	Adams	Asotin	Benton-Franklin	Chelan-Douglas	Clallam	Clark	Columbia	Cowlitz	Ferry	Garfield	Grant	Grays Harbor	Island	Jefferson	King	Kitsap	Kittitas	Klickitat	Lewis	Lincoln	Mason	Okanogan	Pacific	Pend Oreille	Pierce	San Juan	Skagit	Skamania	Snohomish	Spokane	Stevens	Thurston	Wahkiakum	Walla Walla	Whatcom	Whitman	Yakima	
Community: Bonding (opportunity, skills, and recognition)		■			■	■	■	■	■	■				■		■				■						■		■	■	■									
Community: Healthy Beliefs and Clear Standards									■							■			■	■									■										
Family: Bonding (opportunity, skills, and recognition)		■			■				■	■				■		■				■							■												■
Family: Healthy Beliefs and Clear Standards									■				■			■																							
Peer: Bonding (opportunity, skills, and recognition)										■						■				■												■				■	■		
Peer: Healthy Beliefs and Clear Standards																■															■								■
School: Bonding (opportunity, skills, and recognition)																■									■	■													
School: Healthy Beliefs and Clear Standards																■																							

Source: Data compiled from Division of Alcohol and Substance Abuse quarterly reports.

Tribal Prioritized Risk Factors



The table below displays a summary of the prioritized risk factors for the 2003-2005 Biennium being addressed by 22 tribes in Washington State that have prevention contracts with the Division of Alcohol and Substance Abuse.

TARGETED RISK FACTORS ▼	TRIBE	Hoh	Jamestown S'Klallam	Kalispel Tribe of Indians	Lower Elwha Klallam	Makah	Muckleshoot	Nisqually	Puyallup	Quileute	Quinault Nation	Samish Nation	Sauk-Suiattle	Shoalwater Bay	Skamania	Skokomish	Snoqualmie	Spokane Tribe of Indians	Squaxin Island	Stillaguamish	Suquamish	Swinomish	Tulalip	Upper Skagit	Yakama Nation
Academic Failure Beginning in the Late Elementary School																									
Availability of Alcohol/Drugs																									
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Source: Data compiled from Division of Alcohol and Substance Abuse quarterly reports.



Tribal Prioritized Protective Factors

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Community: Bonding (opportunity, skills, and recognition)		■	■	■	■			■	■	■				■	■		■		■		■	■		■	■
Community: Healthy Beliefs and Clear Standards					■		■	■				■	■	■	■	■	■			■	■	■			
Family: Bonding (opportunity, skills, and recognition)									■			■					■								
Family: Healthy Beliefs and Clear Standards									■								■								
Peer: Bonding (opportunity, skills, and recognition)											■	■		■			■					■	■	■	
Peer: Healthy Beliefs and Clear Standards													■	■			■				■				
School: Bonding (opportunity, skills, and recognition)																	■								
School: Healthy Beliefs and Clear Standards																	■								

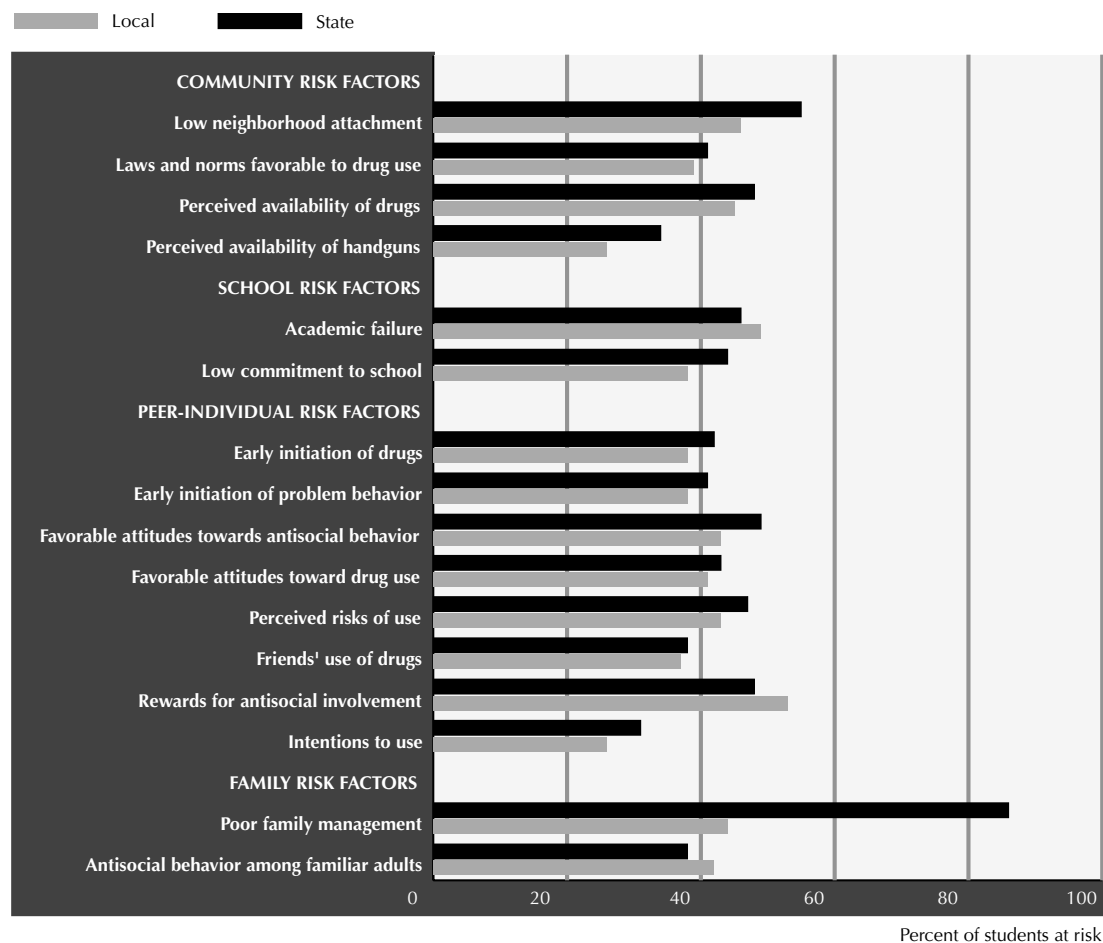
Source: Data compiled from Division of Alcohol and Substance Abuse quarterly reports.

Using Data to Inform County Prevention Planning



In order to make wise decisions about the use of prevention resources, counties rely on having access to sound data, both about their own communities, and how they compare to demographically similar counties and the state as a whole. One source of such data is the Healthy Youth Survey. Counties are presented with data regarding the percentage of youth at risk or protected in each of the risk/protective factor categories.

Below is an example of a chart of risk factor results that a county might receive.

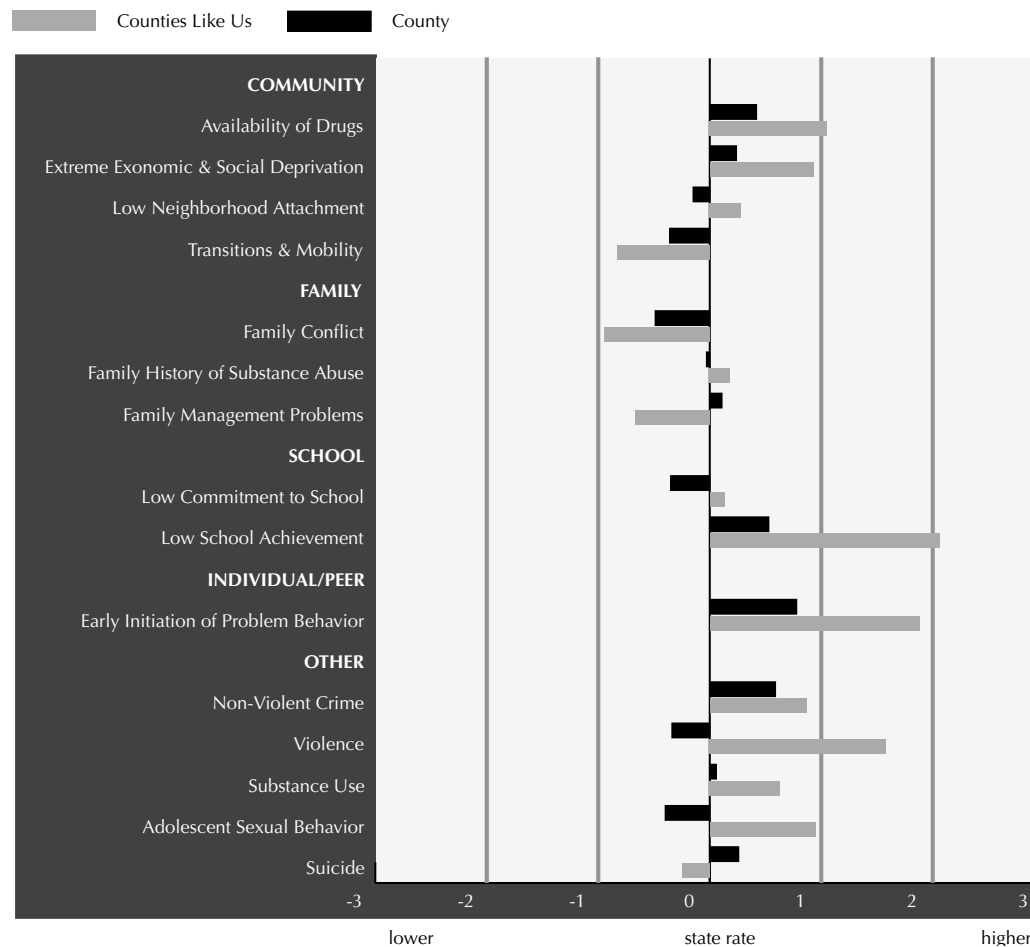




Using Data to Inform County Prevention Planning

In order to make wise decisions about the use of prevention resources, counties rely on having access to sound data, both about their own communities, and how they compare to demographically similar counties, and to the state as a whole. Counties are presented with archival data related to risk factors in their communities. Various archival data sources are utilized to derive a summary measure profile

Below is an example of a chart displaying archival summary measure profile data that a county might receive.



The Division's Prevention Plan



In March 1999, the Governor and the Governor's Substance Abuse Prevention Advisory Committee issued a Washington State Substance Abuse Prevention Plan. Since then, the Washington State Division of Alcohol and Substance Abuse has been working closely with a full range of state and local partners to implement the six specific objectives outlined in the plan

The six objectives are:

1. To identify and adopt a set of common outcome measures building on the emerging consensus of a "science-based" risk and protective factor approach to prevention.
2. To develop and coordinate administration of common community needs and resource assessment tools.
3. To define selection criteria to identify the science-based prevention programs which can best address the needs identified from common assessment and measures.
4. To develop uniform reporting mechanisms that can capture outcomes of individual prevention programs.
5. To develop guidelines for leveraging and redirecting money and resources based on the confidence of the scientifically established outcome measures, uniform community assessments, and reliable reporting.
6. To create a system for continuous professional development for all prevention providers, both volunteer and paid.





Outcomes

Working with a full range of state and local partners in implementing Washington State Substance Abuse Prevention Plan, Washington State Division of Alcohol and Substance Abuse is working toward meeting a series of 15 outcome objectives in four key areas. Statewide targeted benchmarks are set, and measurement tools established for each of the outcomes.

Safety

- Reduce substance abuse-related deaths.
- Reduce the number of people who drink and drive.
- Increase the number of people who feel safe at school.
- Increase the number of communities where substance abuse laws are consistently enforced, and children and youth know that the community's adults stand behind these laws.

Health

- Reduce the number of youth who use alcohol, tobacco, and other drugs.
- Increase the age at which children first experiment with substance use.
- Increase the number of children and youth who are aware of the dangers of substance use.
- Decrease the number of young adults (18 to 24) who smoke, misuse alcohol, or use illicit drugs.
- Increase the number of women who do not use substances during pregnancy.



Social Integration

- Increase the number of youth who spend time each week in pro-social activities that build positive intergenerational relationships, social skills, and a personal sense of accomplishment.
- Increase the attachment and commitment that children and youth feel to those who care for them.

Learning and Skill Building

- Increase the number of children who are successful in elementary school.
- Increase the number of children who believe that school is important, and that it is relevant to their future.
- Increase the number of students who attend school regularly.
- Increase the number of youth who graduate from high school.



Statewide Prevention Services and Programs

The Division of Alcohol and Substance Abuse (DASA) funds statewide services primarily by way of interagency agreements and partnerships with state agencies and non-profit organization. The following programs are either partially or fully funded by DASA:

School-Based Prevention and Intervention Services Program

The Office of Superintendent of Public Instruction (OSPI) administers a school-based program targeting students at risk for developing alcohol, tobacco, and other drug-related problems. During the 2001-2003 Biennium, 292 Prevention/Intervention Specialists implemented programs in ten Educational Service Districts and three school districts. These services were offered in all the regions of the state and were delivered to 22,947 kindergarten through twelfth grade students in 765 schools.

Healthy Youth Survey

OSPI administers an adolescent health behavior survey every other year. Substance abuse prevalence and risk/protective factor data are generated from this survey and used by prevention planners and service providers throughout our state. The 2002 Healthy Youth Survey was the seventh time health-related attitudes and behaviors of Washington's public school students have been assessed. More than 137,000 students in 752 elementary, middle, and high schools across the state participated in the survey.

Reducing Underage Drinking Initiative (RUaD)

RUaD's goal is to prevent or reduce the consumption of alcohol by minors, especially through increased enforcement of underage drinking laws. The RUaD program has received block grant awards totaling \$2,160,000 since 1998 from the federal Office of Juvenile Justice and Delinquency Prevention (OJJDP). The block grants have supported public education efforts, Liquor Control Board enhancements, a RUaD track and/or workshops at the State Prevention Summit, youth leadership activities, and community-based coalitions. In addition to the block grants, DASA is the recipient of two discretionary grants of nearly \$800,000. These funds support the efforts of five communities as they implement comprehensive approaches to the problem of underage drinking, with an emphasis on increasing law enforcement activity. Washington Traffic Safety Commission and the Washington State Liquor Control Board are primary partners in RUaD. Other collaborators include: local law enforcement, Mothers Against Drunk Driving, the statewide College Coalition for Substance Abuse Prevention, and other state agencies.

Reducing Access to Tobacco Products (Synar Regulation)

The Substance Abuse Prevention and Treatment (SAPT) block grant requires that states focus on reducing youth access to tobacco products through retail outlets. The Synar Regulation requires that states reach and maintain a maximum 20% non-compliance rate as measured through compliance checks. Washington has always been in compliance with the Synar regulation. Washington's Synar success is due to DASA's positive and effective relationship with two other state agencies, the



Department of Health (DOH) and the Liquor Control Board. DOH develops a randomized list of tobacco retailers in the state and then asks local health jurisdictions to implement youth access compliance checks. Local health jurisdictions are responsible for implementing the Synar compliance checks assigned to them through the statewide sampling. They report the results of the checks back to DOH. In 2003, the non-compliance rate was 10.8%.

College Coalition for Substance Abuse Prevention

The University of Washington facilitates the College Coalition for Substance Abuse Prevention. Coalition members administer campus-based prevention services targeting students and university communities. The College Coalition was established to provide the development, implementation, and continuation of substance abuse prevention programming at all college and university campuses in Washington State. The coalition meets six times during the academic year on different campuses throughout the state, sponsors the annual Pacific Northwest Conference on Collegiate Wellness, and supports the Washington State Prevention Summit.

Children's Transition Initiative (CTI)

DASA established the Children's Transition Initiative (CTI) to encourage prevention providers to address the risk and protective factors in children transitioning from grade school to middle school and middle school to high school. CTI requires enrollment of children and their families for a minimum of 12 months, and the utilization of research-based prevention strategies. CTI counties include Benton, Columbia, Ferry, Franklin, Grant, Island, Lincoln, Skamania, Spokane, and Whatcom.

Alcohol/Drug Clearinghouse

DASA funds the Alcohol/Drug Clearinghouse to provide a wide variety of timely resource material and information on substance abuse. Materials and information are accessible for Washington State residents, including non-English-speaking individuals and persons with disabilities. The Clearinghouse maintains a statewide toll-free phone number for requesting resources, including a system for receiving requests by telephone from the hearing-impaired community, a website for requesting materials, and a video lending library. Requests for information or materials are usually processed within 24 hours. The Clearinghouse also maintains an electronic newsletter to communicate federal, state, and local prevention news and activities/campaigns to individuals and organizations in Washington State. During the 2001-2003 Biennium, the Clearinghouse distributed over 900,000 resource item, and made resources available to over 200 community and school-based events.



Exemplary Substance Abuse Prevention Awards

The Washington State Exemplary Substance Abuse Prevention Awards Program recognizes outstanding substance abuse prevention programs, including individuals working in the prevention field, and media organizations that support prevention efforts. A review committee evaluates the nominations and approves those meeting the selection criteria. Members of the committee also nominate and select additional awardees for their special contributions to the field. The state awards process is designed to coordinate with the existing national awards process, with the goal of identifying Washington State Exemplary Programs that could be encouraged to apply at the national level. The awards process is conducted in cooperation with the Governor's Prevention Advisory Committee, the Lieutenant Governor's Office, the Citizens Advisory Council on Alcoholism and Drug Addiction, and the Washington Interagency Network.

Community Prevention Capacity Building

Until the start of the 2003-2005 Biennium, the Community Prevention Training System provided financial support to counties and tribes for capacity building. Now each county has a set amount of funding specifically earmarked for training. It may choose to improve its own abilities to plan and develop programming, or support community members whose participation in training would fill an identified need.

Communication and Media Program

DASA's Communication and Media Program provides materials and technical assistance to communities in Washington State to increase public awareness about the prevention and treatment of alcohol and other drug misuse and dependency. In addition, DASA manages and supports Partnership for a Drug Free Washington (PDFW), a statewide, ongoing media campaign allied with the Partnership for a Drug-Free America. Support for PDFW includes 30 media and corporate partners statewide who have contributed over \$2 million in airtime and print advertising.

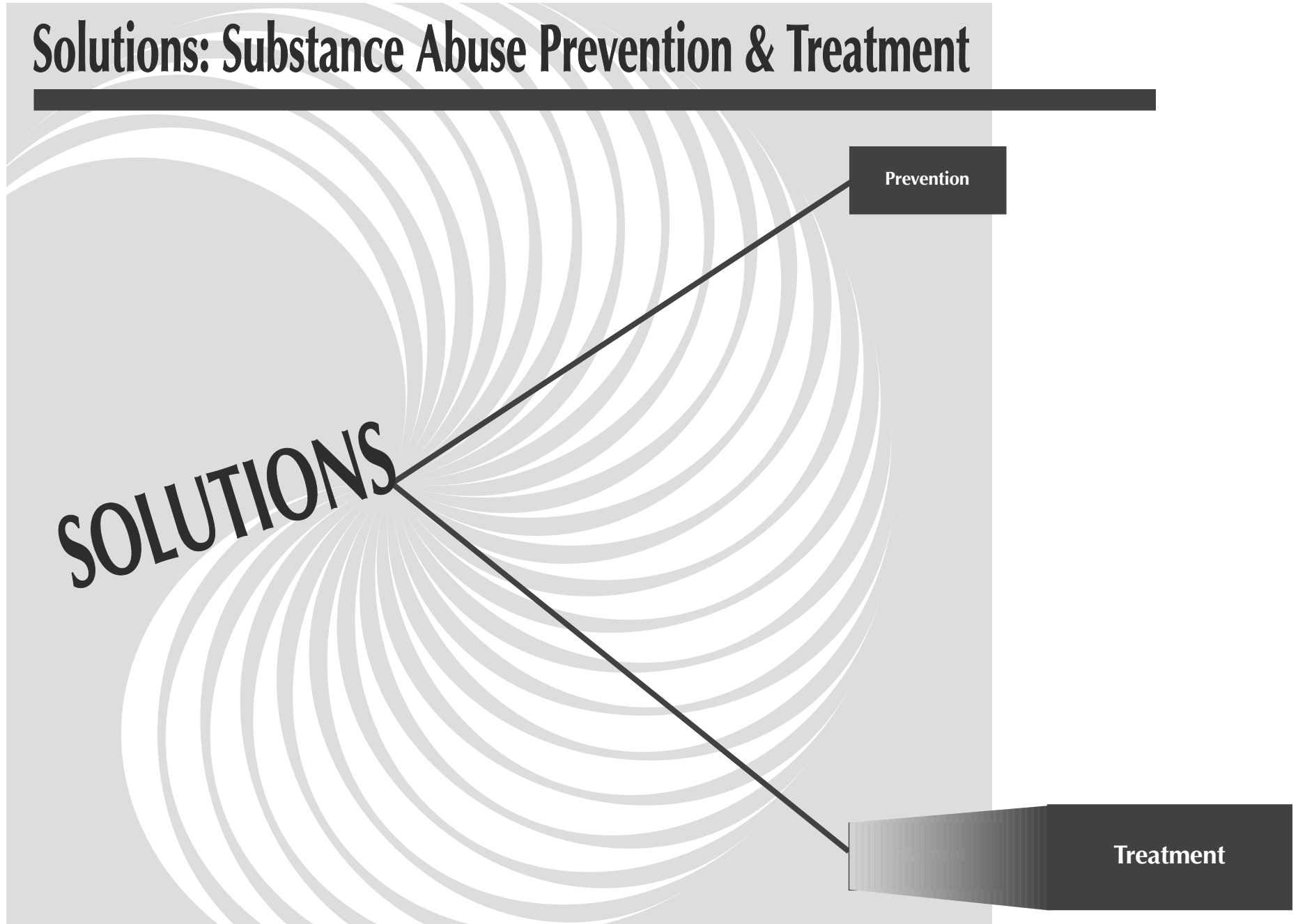
Through partnerships with corporations, state and community agencies, and advertising and news media, DASA educates the public about the health, social and economic impact of drug misuse and dependency; alcohol and other drug prevalence and trends; risk and protective factors, media literacy; effective ways to prevent and reduce misuse, and how to access prevention and treatment resources. Messages and campaigns are tailored for professionals, educators, parents, teens, youth, and older adults. Materials are available in English, Spanish, Russian, and Asian languages.

Solutions: Substance Abuse Prevention & Treatment

SOLUTIONS

Prevention

Treatment



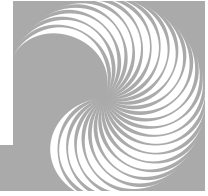


Introduction

Individuals are eligible for DASA-funded services if they are low-income or indigent, and are assessed as chemically dependent. For persons applying for treatment under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA), eligibility is further restricted to those who are unemployable as a result of their alcohol or other drug addiction. Treatment services are designed to maintain a cost-effective, quality continuum of care for rehabilitating alcoholics and drug addicts.

Contracted treatment services include:

- Diagnostic evaluation
- Alcohol/Drug detoxification
- Outpatient treatment
- Opiate substitution (methadone) treatment
- Intensive inpatient treatment
- Recovery house
- Long-term residential care
- Involuntary treatment/civil commitment for individuals with alcohol/drug addiction
- Youth residential treatment
- Youth outpatient treatment
- Residential treatment for pregnant and parenting women (with child care)
- Outpatient treatment for pregnant and parenting women (with child care)
- Treatment for co-occurring disorders
- Tribal treatment programs
- Monolingual programs for non-English speakers
- Treatment program for the deaf/hard of hearing
- Urine screening
- Brief interventions and referral from emergency departments



Specialized contracted support services for eligible individuals include:

- Child care
- Translation services (including interpreters for persons who are deaf or hard of hearing)
- Transportation assistance
- Case management
- Youth outreach
- Cooperative housing (Oxford House) and other transitional housing support

State and federal funding requirements give priority for treatment and intervention services to the following:

- Pregnant and postpartum women and families with children
- Families receiving Temporary Assistance for Needy Families (TANF)
- Child Protective Services referrals
- Youth
- Injection drug users (IDUs)
- People with HIV/AIDS



DASA Treatment Philosophy for Alcohol, Tobacco, and Other Drug Addiction

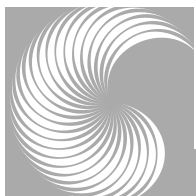
DASA's program of substance abuse services is based on knowledge gained from medical research that alcoholism and addiction to other drugs is a progressive disease. Research and evaluation studies cited throughout this report indicate that long periods of sobriety, abstinence, and/or reduced drug use result from effective intervention and treatment. Research also demonstrates that treatment results in a marked reduction in negative consequences for the addicts, their families, friends, and society at large, as measured by domestic violence, disrupted families, employment histories, and public costs for law enforcement and the courts, welfare dependence, medical and hospital costs, and admissions to psychiatric hospitals.¹ As alcoholism and addiction are chronic, relapsing disorders, continued treatment and support services may be required after any initial course of treatment.

Alcohol, tobacco, or other drug addiction is an individual, family, worksite, and community affliction. These addictions negatively impact all sectors of society regardless of age, education, race/ethnicity, gender, occupation, or socio-economic status. Therefore, it is critical that all citizens – especially teachers, employers, parents, and youth – understand the illness is treatable and the channels for getting a person into private or public treatment agencies. DASA's philosophy recognizes the importance of ensuring all treatment agencies meet established standards for providing services. Treatment must be tailored to the specific needs of each individual, and a continuum of treatment services is essential for matching clients with the optimal types and sequences of treatments. It is also important that specialized treatment services be available for populations with special needs and circumstances, such as adolescents, pregnant and parenting women (and their children), members of minority populations, and those with disabilities.

DASA recognizes that substance abuse treatment cannot occur in isolation from law enforcement and public safety, educational institutions, and social, health, and economic services. It is essential that substance abuse treatment have linkages with all segments of society that are important to recovery and rehabilitation.

A key aspect of DASA's philosophy is recognizing the generational loop of addiction. It is important to break the generational cycle of addiction by promoting alcohol, tobacco, and other drug prevention programs, enrolling children of addicts in appropriate prevention activities, and providing early intervention services when needed.

¹See, for example: Wickizer, T., and Longhi, D. (1997). Economic benefits and costs associated with substance abuse treatment provided to indigent clients through the Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA). Olympia, WA: Washington State Department of Social and Health Service, Division of Alcohol and Substance Abuse. See also: Schrager, L. Joyce, J., and Cawthon, L., (1995). Substance abuse, treatment, and birth outcomes for pregnant and postpartum women in Washington State. Olympia, WA: Washington State Department of Social and Health Services, Planning, Research & Development and Office of Research & Data Analysis.



Substance Use and Current Need for Treatment

Based on the *2003 Washington State Needs Assessment Survey* conducted by the Department of Social and Health Services' Research and Data Analysis Division, 10.9% of the Washington State adult population (age 18 and older) living in households were estimated to be in need of substance abuse treatment in 2003.¹ Treatment need for adolescents (ages 12 to 17) living in households is estimated at 8.7%. (The definition of need for treatment is provided on the following page.)

Alcohol is by far the most used substance in Washington State, and the one for which there is the highest rate of treatment need.

Use rates among adults living in households for individual substances were as follows:

	Lifetime Use	Past 12-Month Use	Past 30-Day Use
Alcohol	88.0%	72.9%	57.9%
Any Illicit Drug	45.2%	9.6%	5.6%
Marijuana	42.2%	7.4%	4.3%
Stimulants*	14.5%	0.5%	0.1%
Cocaine	15.8%	1.1%	0.9%
Opiates**	8.7%	2.0%	0.9%
Heroin	1.7%	0.1%	0.0%

* Includes amphetamine, methamphetamine, and other stimulants.

** Other than heroin.

¹ *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.



Current Need for Treatment Among Population Subgroups in Washington State

Based on data from the 2003 Washington State Needs Assessment Household Survey conducted by the Department of Social and Health Services' Research and Data Analysis Division, the current estimated need for treatment varies widely across population subgroups:

- Compared with the overall treatment need rate of 10.9% of adults living in households, some subgroups have lower rates of treatment need. These include: those ages 45-64 (7.8%) and 65+ (1.8%); females (7.3%); African-Americans (10.4%) and Asians (4.9%); those who are married (5.9%); and college graduates (8.1%).
- Other subgroups have higher estimated needs for treatment. These include: (those ages 18-24 (22.6%) and 25-44 (13.0%); males (14.7%); American Indians (15.8%) and multi-race individuals (16.2%); and those never married (21.0%).

Need for chemical dependency treatment is associated with income. Adults living in households with incomes above 200% of the Federal Poverty Level (FPL) have lower rates of treatment need (10.0%) than do adults living in households with incomes below 200% FPL (13.6%).

Those classified as in need of chemical dependency treatment in the past year met one or more of the following conditions.

1. Reported life DSM-IV* alcohol or drug abuse or dependence symptoms, reported at least one symptom in the past 12 months, and used alcohol or drugs in the past 12 months.
2. Received professional alcohol or drug treatment (excluding detoxification) during the past 12 months.
3. Reported having a problem with alcohol or drugs and was using alcohol or drugs regularly during the past 12 months. Regular alcohol use is defined as having three or more drinks at least one day per week. Regular drug use is defined as using marijuana 34 or more times in the past 12 months or as using other illicit drugs eight or more times in the past 12 months.
4. Reported heavy use of drugs or alcohol in the past 12 months. Heavy alcohol use is defined as four or more drinks per drinking day, three or more days per week during the past 12 months. Heavy drug use is defined as using any illicit substance 34 or more times during the past 12 months.

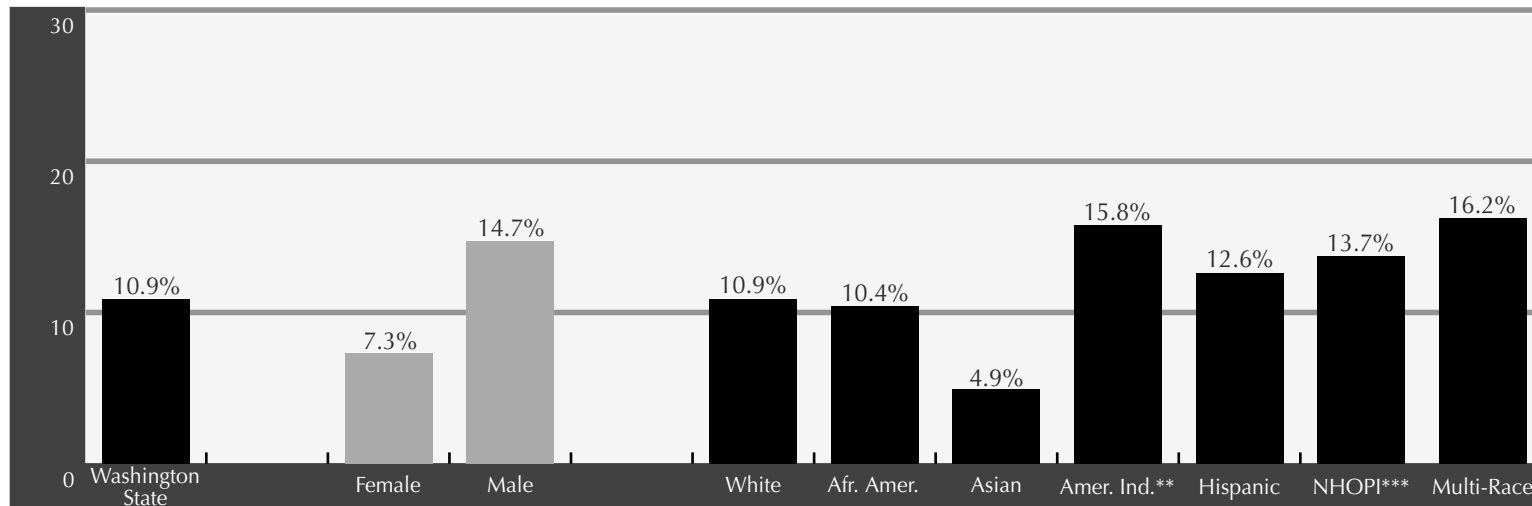
**DSM-IV is the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association in 1994. It contains diagnostic criteria for the most common mental disorders, and includes findings on description, diagnosis, treatment, and research.*



More than One Out of Ten Washington State Adult Residents is in Need of Chemical Dependency Treatment.*

Current Need for Treatment

Percent of Adults in Households



Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

* For definition of Current Need for Treatment, see page 170.

** American Indian Includes Alaskan Natives.

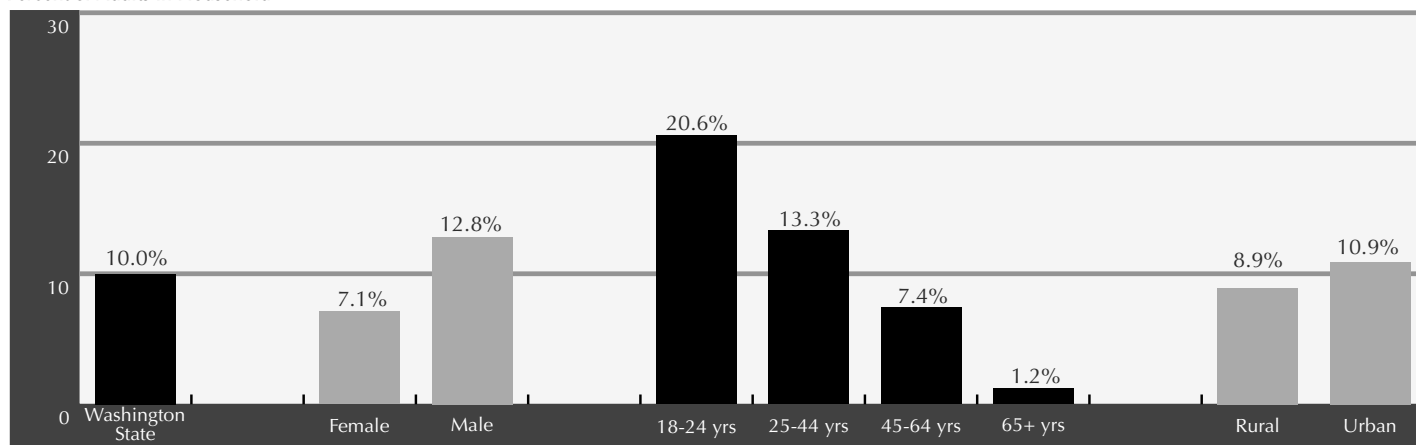
*** Native Hawaiian or Pacific Islander.

Younger Adults (Ages 18-24), Males, and Urban Residents Have Higher Rates of Need for Chemical Dependency Treatment.*



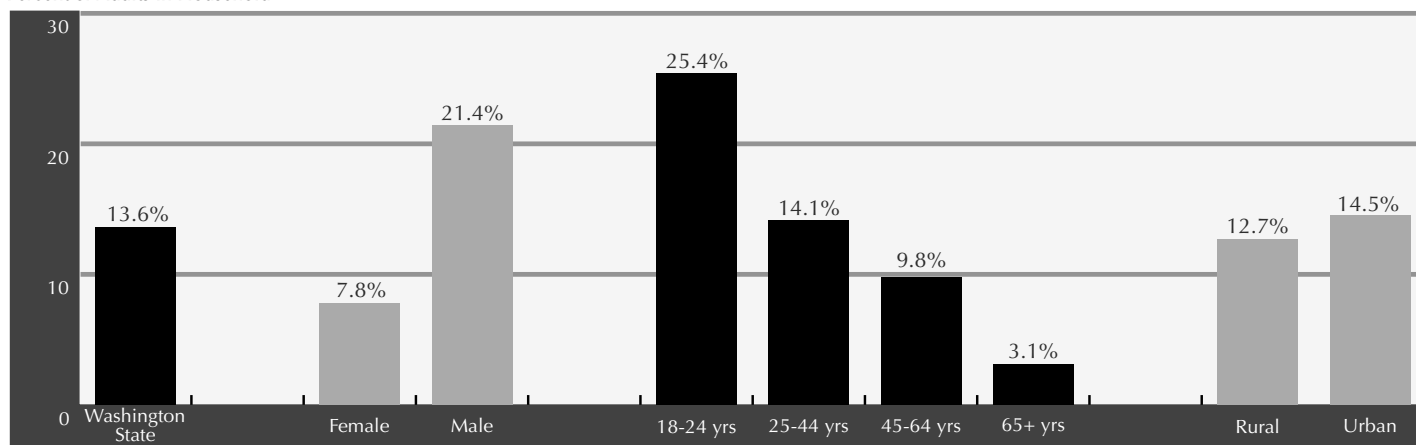
Current Need for Treatment Among Adults Above 200% of Federal Poverty Level

Percent of Adults in Household



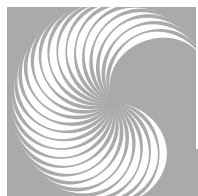
Current Need for Treatment Among Adults at or Below 200% of Federal Poverty Level

Percent of Adults in Household



Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

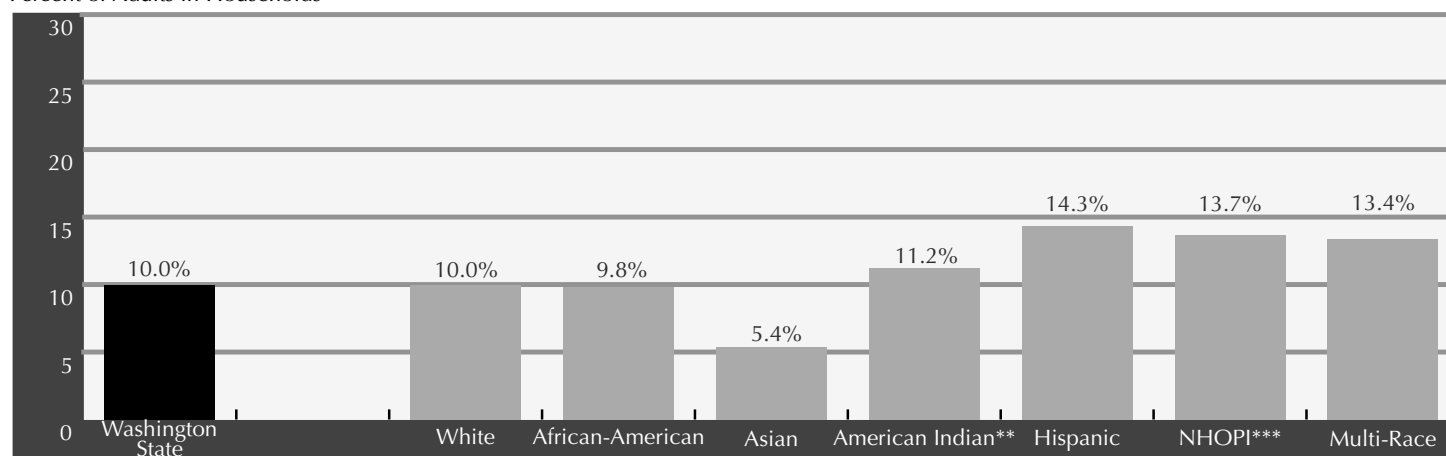
* For definition of Current Need for Treatment, see page 170.



White, American Indian, and Multi-Race Washington State Adult Residents Have Higher Rates of Chemical Dependency Treatment Need.*

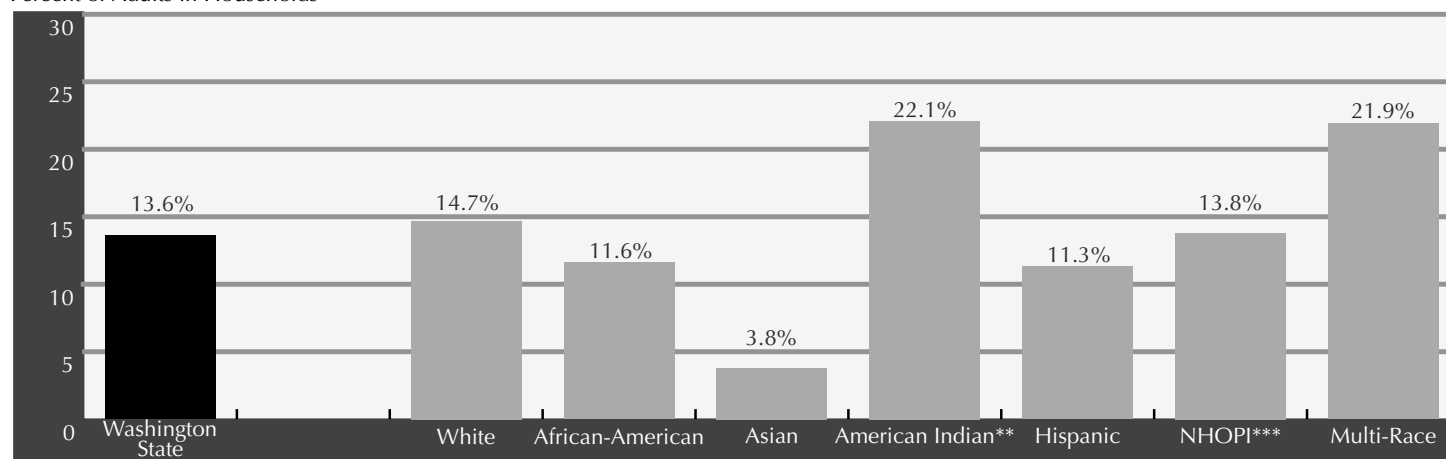
Current Need for Treatment for Adults Above 200% of the Federal Poverty Level

Percent of Adults in Households



Current Need for Treatment for Adults at or Below 200% of the Federal Poverty Level

Percent of Adults in Households



Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

*For definition of Current Need for Treatment, see page 170.

**American Indian includes Alaskan Natives.

***Native Hawaiian or Pacific Islander.

Computing the DASA Treatment Gap



The Treatment Gap rate is a measure over a given period of time of those who qualify – both clinically and financially – for DASA-funded treatment services but who, because of the limits of available funding, do not receive it. To compute the treatment gap, an estimate is established of all those at or below 200% of the Federal Poverty Level (FPL) and in need of treatment. Those who are enrolled in the subsidized portion of the Washington Basic Health Plan (BHP) are subtracted from this number. Those receiving BHP with public subsidies would be expected to access chemical dependency treatment services without additional use of DASA funds.

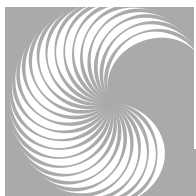
The following equation is then used to compute the DASA Treatment Gap =

$$\text{DASA Treatment Gap Rate} = \frac{\text{\# of county residents qualifying for and requiring DASA-funded treatment minus those receiving it}}{\text{\# of county residents qualifying for and requiring DASA-funded treatment}} \times 100$$

The statewide treatment gap is computed by aggregating the county number and using the same formula. Counts of persons receiving DASA-funded treatment were drawn from DASA's TARGET management information service. These counts represent cases that were open in SFY 2001. Individuals must have received at least one residential or outpatient service during this period. Persons receiving more than one treatment service are only counted once.

Only those living in households are included. Those residing in institutions or group care settings are excluded from both the numerator and the denominator.* Results by county and statewide are displayed on the following page.

**For a fuller discussion of the methodology used to determine the treatment gap rate, contact the Office of Planning, Policy, and Legislative Relations, Division of Alcohol and Substance. Address and phone number are found on the back cover.*



The Treatment Gap

SFY 2003 Treatment Gap Rates in Washington State for Publicly Funded Chemical Dependency Services

Target Population	Needing & Eligible for DASA-Funded Treatment	Received Treatment with DASA-Funded Support	Number of Eligible Individuals Unserved	Treatment Gap Rate (Unserved Need)
Adults w/children < 18	55,326	10,554	44,772	80.9%
Adults w/o children under 18	66,538	14,785	51,753	77.8%
ALL ADULTS 18 AND OLDER	121,864	25,339	96,525	79.2%
ADOLESCENTS (AGES 12 - 17)	24,981	5,875	19,106	76.5%
TOTAL	146,845	31,214	115,631	78.7%

Excludes detox and transitional housing, private-pay patients, and Department of Corrections.

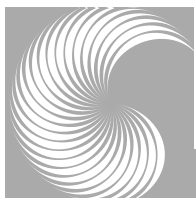
**For a fuller discussion of the methodology used to determine the treatment gap rate, contact the Office of Planning, Policy, and Legislative Relations, Division of Alcohol and Substance. Address and phone number are found on the back cover.*

Statewide, in SFY 2003, 79.2% of Adults in Households Who Qualified for and were in Need of DASA-Funded Chemical Dependency Treatment Did Not Receive It.



County	Percent of Adults <200% FPL & in need of Treatment	Number of Adults <200% FPL Receiving Treatment	Number of Adults Not Receiving Treatment	Penetration Rate	Treatment Gap	
Adams	12.0%	62	272	18.5%	81.5%	Whitman 96.1
Asotin	14.3%	119	391	23.3%	76.7%	Kittitas 90.1
Benton	13.8%	777	2,234	25.8%	74.2%	Spokane 87.4
Chelan	12.7%	438	968	31.1%	68.9%	King 85.1
Clallam	13.4%	579	1,036	35.8%	64.2%	Clark 83.1
Clark	14.2%	1,068	5,252	16.9%	83.1%	Douglas 83.0
Columbia	12.3%	54	20	72.9%	27.1%	Whatcom 82.8
Cowlitz	14.0%	803	1,817	30.7%	69.3%	Klickitat 82.2
Douglas	12.3%	117	570	17.0%	83.0%	Stevens 82.0
Ferry	16.8%	113	208	35.2%	64.8%	Adams 81.5
Franklin	11.7%	371	917	28.8%	71.2%	Grant 81.0
Garfield	13.0%	15	36	29.4%	70.6%	Thurston 80.1
Grant	13.1%	422	1,799	19.0%	81.0%	Jefferson 79.9
Grays Harbor	13.3%	486	1,560	23.8%	76.2%	Lincoln 79.2
Island	13.8%	246	802	23.5%	76.5%	Pierce 79.0
Jefferson	12.9%	117	464	20.1%	79.9%	Snohomish 78.3
King	13.8%	4,567	26,114	14.9%	85.1%	Lewis 77.6
Kitsap	14.2%	1,042	3,358	23.7%	76.3%	Asotin 76.7
Kittitas	20.6%	197	1,792	9.9%	90.1%	Island 76.5
Klickitat	13.8%	112	518	17.8%	82.2%	Kitsap 76.3
Lewis	13.5%	409	1,417	22.4%	77.6%	Grays Harbor 76.2
Lincoln	12.3%	49	186	20.8%	79.2%	Walla Walla 74.5
Mason	14.3%	329	838	28.2%	71.8%	Benton 74.2
Okanogan	13.7%	496	947	34.4%	65.6%	Mason 71.8
Pacific	12.0%	204	350	36.8%	63.2%	Franklin 71.2
Pend Oreille	13.5%	124	262	32.1%	67.9%	Garfield 70.6
Pierce	13.7%	2,953	11,115	21.0%	79.0%	Skagit 70.2
San Juan	13.3%	87	183	32.2%	67.8%	Cowlitz 69.3
Skagit	12.8%	641	1,513	29.8%	70.2%	Chelan 68.9
Skamania	13.8%	81	171	32.2%	67.8%	Pend Oreille 67.9
Snohomish	13.2%	1,958	7,085	21.7%	78.3%	Skamania 67.8
Spokane	16.1%	1,680	11,622	12.6%	87.4%	San Juan 67.8
Stevens	14.3%	227	1,037	18.0%	82.0%	Okanogan 65.6
Thurston	15.5%	846	3,403	19.9%	80.1%	Ferry 64.8
Wahkiakum	15.3%	56	2	96.3%	3.7%	Clallam 64.2
Walla Walla	15.1%	312	912	25.5%	74.5%	Pacific 63.2
Whatcom	18.5%	1,089	5,248	17.2%	82.8%	Yakima 62.4
Whitman	23.2%	110	2,679	3.9%	96.1%	Columbia 27.1
Yakima	12.3%	1,983	3,295	37.6%	62.4%	Wahkiakum 3.7

*For a fuller discussion of the methodology used to determine the treatment gap rate, contact the Office of Planning, Policy, and Legislative Relations, Division of Alcohol and Substance Abuse. Address and phone are found on the back cover.



Estimates of Substance Abuse and Treatment Need in Washington State, 2003

	Adult Household Residents		Adults in Households At or Below 200% of Federal Poverty Level	
	# of Residents	% of Residents	# of Residents	% of Residents
NEED FOR TREATMENT				
Current Need for Substance Treatment	462,815	10.9%	139,448	13.6%
ALCOHOL OR DRUG DISORDER				
Lifetime Alcohol or Drug Use Disorder	870,902	20.5%	210,317	20.5%
Past 12-Month Alcohol or Drug Use Disorder	330,865	7.8%	95,597	9.3%
ALCOHOL USE				
Lifetime Use of Alcohol	3,741,029	88.0%	790,362	77.2%
Past 12-Month Use of Alcohol	3,101,524	72.9%	597,710	58.4%
Past 30-Day Use of Alcohol	2,462,349	57.9%	426,208	41.6%
ALCOHOL DISORDER				
Lifetime Alcohol Use Disorder	726,096	17.1%	161,905	15.8%
Past 12-Month Alcohol Use Disorder	298,412	7.0%	78,715	7.7%
USE OF ANY DRUG				
Lifetime Use of Any Illicit Drug	1,922,080	45.2%	427,751	41.8%
Past 12-Month	410,060	9.6%	130,412	12.7%
Past 30-Day Use of Any Illicit Drug	239,522	5.6%	77,073	7.5%
MARIJUANA USE				
Lifetime Use of Marijuana	1,793,182	42.2%	392,656	38.4%
Past 12-Month Use of Marijuana	314,548	7.4%	98,067	9.6%
Past 30-Day Use of Marijuana	184,432	4.3%	59,931	5.9%
STIMULANT USE				
Lifetime Use of Stimulants	614,880	14.5%	148,988	14.6%
Past 12-Month Use of Stimulants	21,610	0.5%	12,079	1.2%
Past 30-Day Use of Stimulants	5,858	0.1%	4,567	0.4%
COCAINE USE				
Lifetime Use of Cocaine	670,067	15.8%	161,918	15.8%
Past 12-Month Use of Cocaine	47,347	1.1%	20,549	2.0%
Past 30-Day Use of Cocaine	14,989	0.4%	6,759	0.7%
DRUG DISORDER				
Lifetime Drug Use Disorder	306,505	7.2%	98,899	9.7%
Past 12-Month Drug Use Disorder	76,888	1.8%	35,864	3.5%

Source: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2004.

Estimates of Current Need for Substance Abuse Treatment in Washington State, 2003.

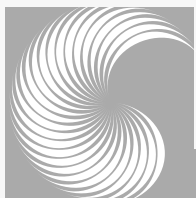
	Adult Household Residents			Adults In Household at or below 200% of Federal Poverty Level		
GROUP	Population	# Needing Treatment	% Needing Treatment	Population	# Needing Treatment	% Needing Treatment
Total	4,253,004	462,815	10.9%	1,023,468	139,448	13.6%
AGE						
18-24	493,426	111,581	22.6%	210,242	53,345	25.4%
25-44	1,692,783	228,060	13.5%	424,809	60,034	14.1%
45-64	1,447,675	112,212	7.8%	209,305	20,589	9.8%
65+	619,120	10,962	1.8%	179,111	5,480	3.1%
SEX						
Male	2,075,077	304,908	14.7%	446,459	95,661	21.4%
Female	2,177,927	157,907	7.3%	577,008	43,787	7.6%
RACE/ETHNICITY						
White-NH	3,472,004	379,729	10.9%	699,451	102,504	14.7%
Black-NH	117,060	12,214	10.4%	39,547	4,598	11.6%
Asian	238,174	11,598	4.9%	78,892	3,012	3.8%
Amer. Indian*	54,178	8,576	15.8%	23,098	5,096	22.1%
NHOPI**	11,844	1,626	13.7%	4,455	615	13.8%
Multi-Race	101,351	16,441	16.2%	33,554	7,336	21.9%
Hispanic	258,393	32,361	12.6%	144,471	16,289	11.3%
MARITAL						
Married	2,532,484	201,467	8.0%	440,169	43,424	9.9%
Div/Sep	628,170	70,275	11.2%	204,895	22,240	10.9%
Widowed	248,837	9,820	3.9%	100,522	3,638	3.6%
Never Mar	843,513	181,253	21.5%	277,882	70,146	25.2%
EDUCATION						
Not HS Grad	342,765	39,359	11.5%	204,726	22,269	10.9%
HS Graduate	3,910,239	423,456	10.8%	818,742	117,180	14.3%
POVERTY						
Below 200%	1,023,468	139,448	13.6%	204,726	22,269	10.9%
Above 200%	3,229,536	323,367	10.0%	-	-	-
*American Indian includes Alaskan Native.						
**Native Hawaiian or Pacific Islander						

Treatment Admission Trends

**Treatment
Admission**

Adult

Youth



Modality categories are defined as follows:

Detoxification

Detoxification is a short-term residential service for individuals withdrawing from the effects of excessive or prolonged alcohol or drug abuse. Services continue only until the person recovers from the transitory effects of acute intoxication. Detoxification always includes supervision and may include counseling and/or medical care and use of pharmacological agents. Some counties provide detoxification in specialized freestanding facilities; in other counties, detoxification is provided in community hospitals.

Intensive Inpatient

Intensive inpatient treatment is a highly structured program for chemically dependent persons in a residential setting. Services emphasize alcohol and drug education and individual and group therapy. The length of stay in intensive inpatient treatment for adults is based on American Society for Addiction Medicine (ASAM) criteria.

Recovery House

Recovery houses provide social, recreational, and occupational therapy as well as treatment in a drug/alcohol-free residential setting. The program emphasizes helping patients re-enter the community and the outpatient phase of treatment.

Long-Term Residential

Long-term residential treatment is a specialized program for chemically dependent persons who require periods of treatment in excess of 90 days. It includes domiciliary care, counseling, and other therapies to patients who reside at the treatment facility.



Other Residential

This category includes transitional housing, residential treatment for co-occurring chemical dependency and mental health disorders, and on-site group care enhancement services for youth.

Transitional housing provides pregnant and parenting women who have completed chemical dependency treatment with up to 18 months of housing. In conjunction with the housing component, women receive case management services that monitor participation in off-site treatment, prepare clients for self-sufficiency, and link women and their children to other needed services.

Co-occurring disorders programs are provided in residential chemical dependency treatment facilities. Utilizing a group care enhancement model, mental health professionals at the facilities provide assessment, education, in-service training for staff, and linkages to mental health providers in the community.

Through group care enhancement contracts, adolescent chemical dependency treatment providers are able to deliver on-site services to children residing in Department of Social and Health Services children's residential facilities. These include select group homes operated by the Division of Children and Family Services, the Mental Health Division, and the Juvenile Rehabilitation Administration. Providers are able to provide individual drug and alcohol assessments; individual, group, and family treatment; prevention and education groups; training of residential agency staff; case planning and consultation, and linkages to other community alcohol and drug services.

Outpatient and Intensive Outpatient Treatment

Outpatient treatment services consist of a variety of diagnostic and treatment services provided according to a prescribed treatment plan in a non-residential setting. Outpatient treatment provided for indigent patients under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) includes vocational counseling and other efforts to help patients regain employment.

Opiate Substitution Treatment

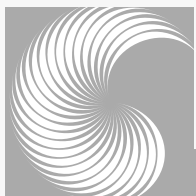
Opiate substitution treatment is an outpatient service for individuals addicted to heroin or other opiates. State-funded and accredited opiate substitution treatment agencies provide counseling and daily or near-daily administration of methadone or other approved substitute drugs.

Treatment Admission Trends

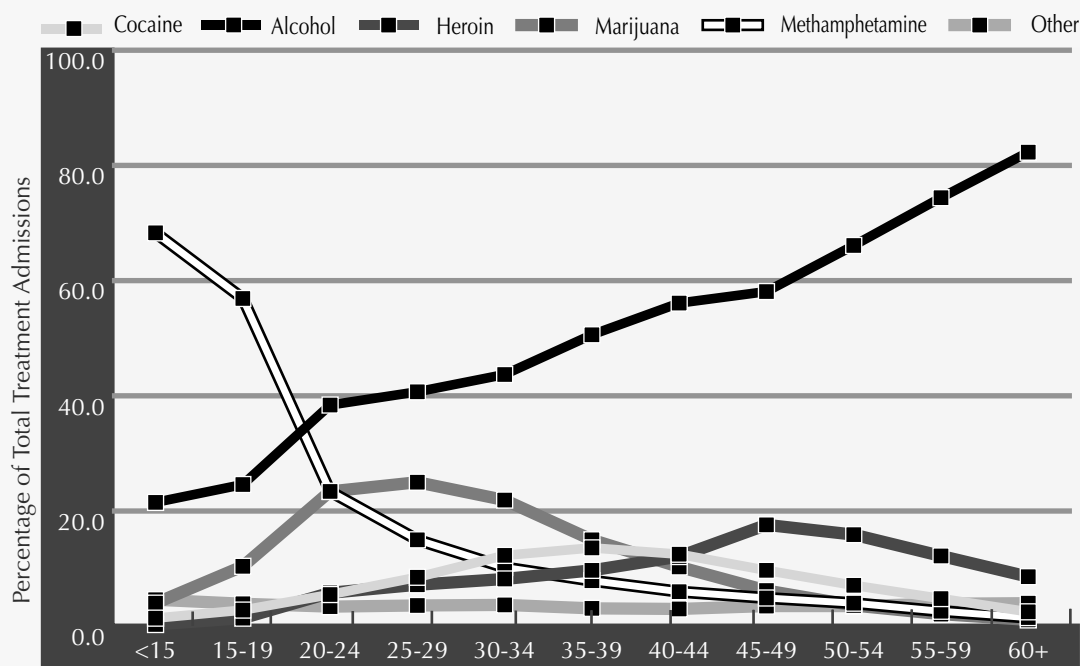
**Treatment
Admission**

Adult

Youth



Primary Drug of Abuse in DASA-Funded Treatment Admissions Varies Significantly By Age.*

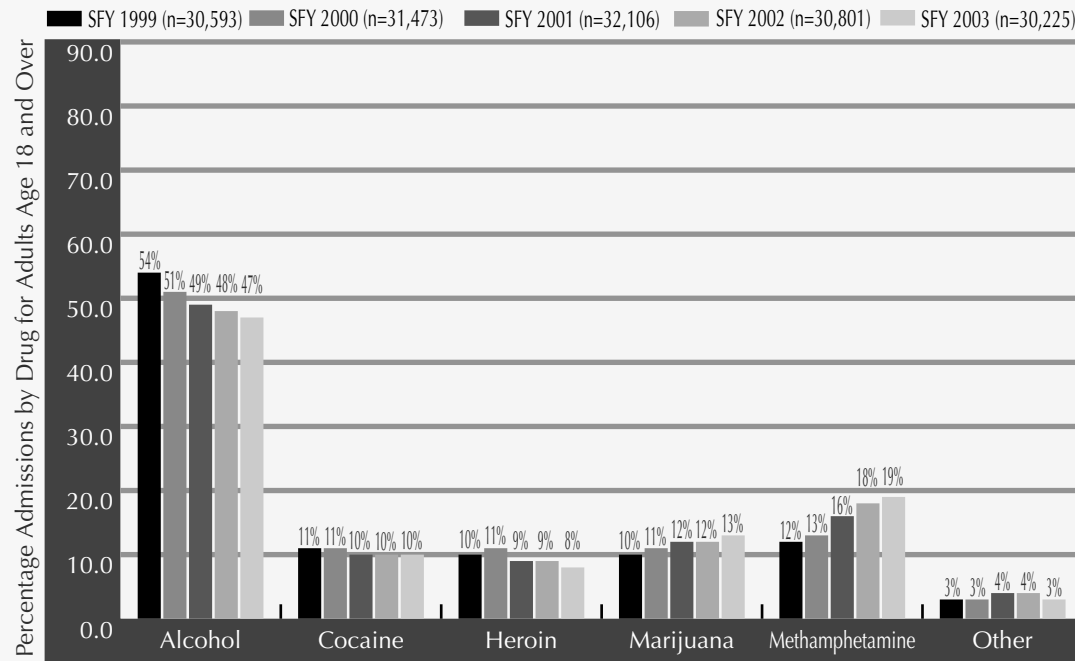


Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

Primary drug of abuse upon treatment admissions reflects drug use in the wider population. This graph indicates that DASA-funded admissions by primary drug of abuse vary widely by age cohort. As a percentage of total admissions, treatment admissions for alcohol consistently rise as the population ages. The vast majority of treatment admissions for marijuana occur in the under-25 population. Methamphetamine admissions are highest among individuals in their twenties. Heroin admissions peak among the population in their late forties.

*Excludes detoxification and transitional housing.

Alcohol is Cited as the Primary Drug of Abuse in the Plurality of Adult Admissions to DASA-Funded Treatment.*



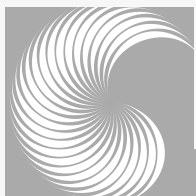
Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse Department of Social and Health Services.

This graph indicates that in SFY 2003, alcohol was the primary drug of abuse for a plurality of adult admissions to DASA-funded admissions. Admissions to treatment for methamphetamine abuse continue to rise.

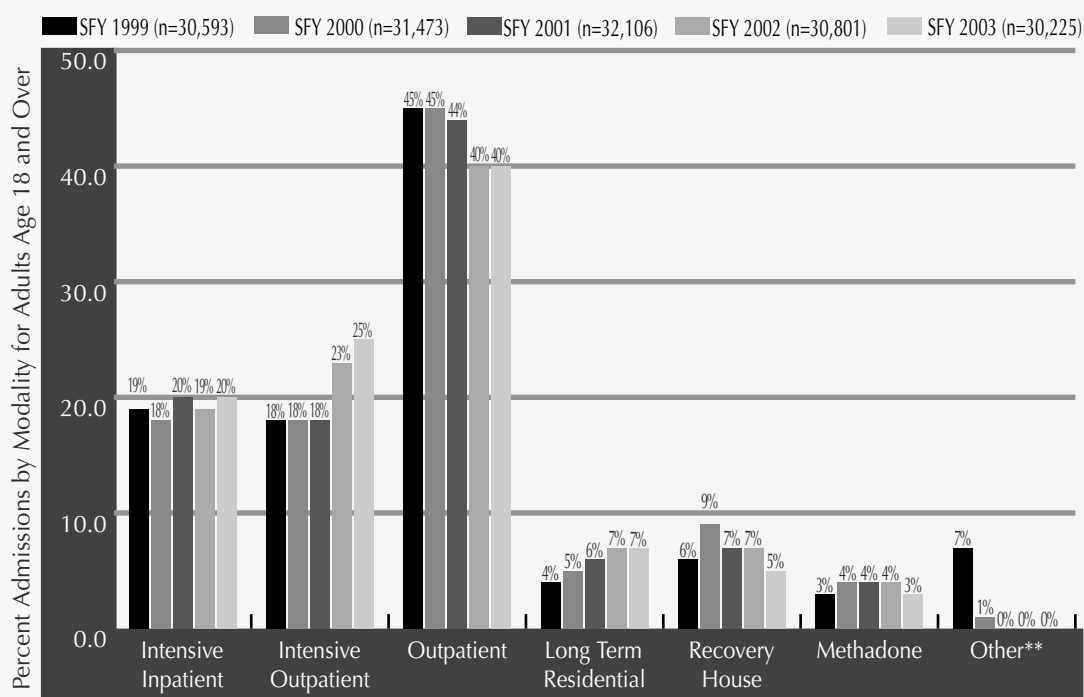
The number of total admissions to DASA-funded treatment has declined in the past two years. Much of this drop is due to DASA's increased emphasis on treatment retention and completion, which has been demonstrated to result in better outcomes.

Note: Data may include multiple admissions for a single individual over the course of a year.

*Excludes detoxification and transitional housing.



About Two Thirds of Adult Admissions to DASA-Funded Treatment are for Outpatient and Intensive Outpatient Services.*



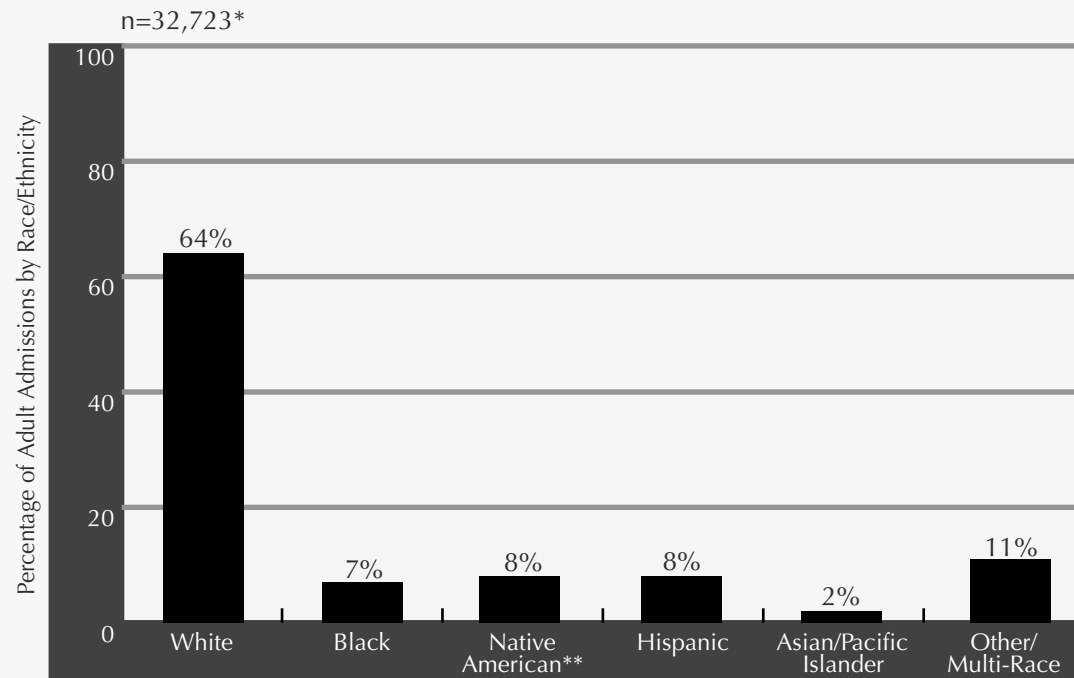
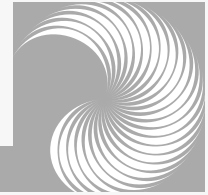
Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

This graph indicates that almost two thirds of adult admissions to DASA-funded chemical dependency treatment are for intensive outpatient and outpatient services. The total number of admissions has fallen 4.0% since SFY 2000, as there is increased emphasis on treatment completion and retention. The number of intensive outpatient admissions has risen 35.3% since SFY 1999.

*Excludes detoxification and transitional housing.

**"Other" includes separate treatment services for those with co-occurring disorders. Prior to SFY 2000, "Other" also included "Extended Care", a modality that has since been phased out.

Racial and Ethnic Minorities Comprise 36% of Adult Admissions to DASA-Funded Chemical Dependency Treatment Services.

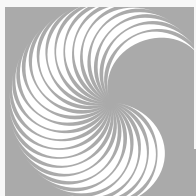


Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

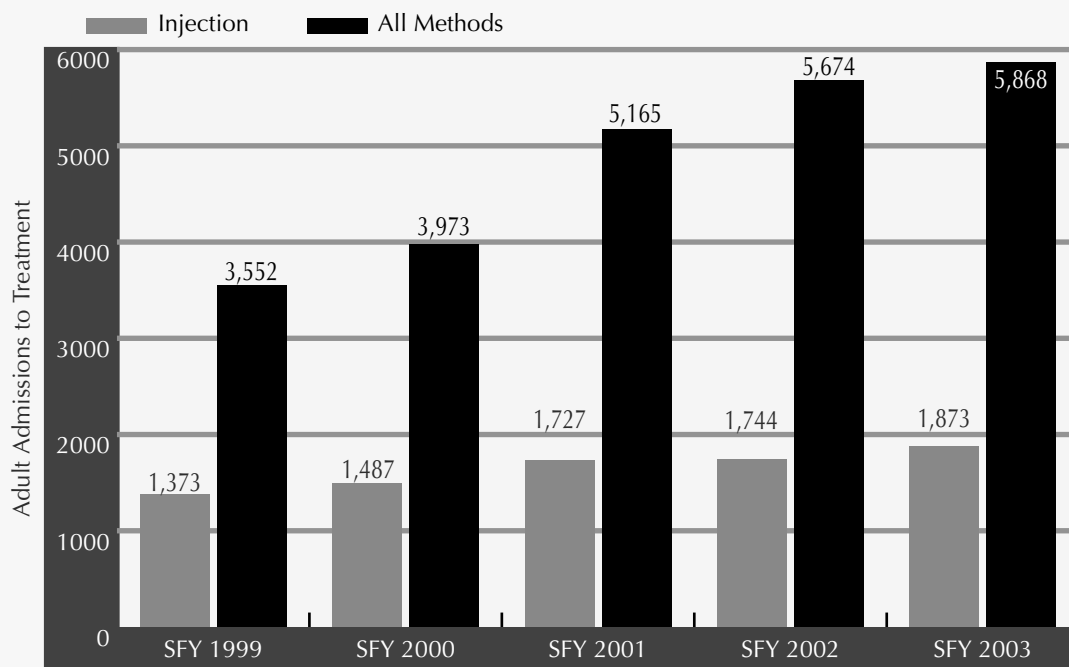
This graph indicates that racial/ethnic minorities comprise approximately 36% of adult admissions to DASA-funded chemical dependency treatment. Percentages of adults from different groups receiving DASA-funded treatment vary across modalities.

* In the U.S. Census, "Hispanic" is listed as an ethnicity, rather than as a racial group. Hence, Hispanic admissions may be duplication in the racial categories.

** Includes Eskimo/Alaskan Native/Aleut



The Number of Adults Admitted to DASA-Funded Treatment for Methamphetamine Use Continues to Rise.



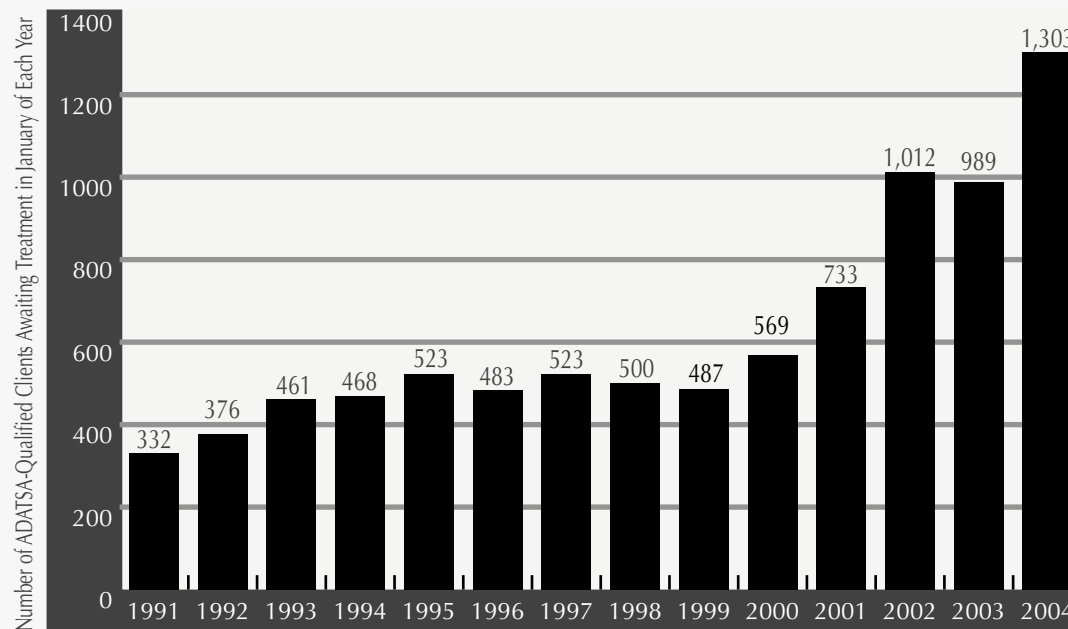
Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

The number of adults admitted to DASA-funded treatment for methamphetamine continues to rise, though the rate of increase now appears to have slowed. The majority of adults admitted to DASA-funded treatment for methamphetamine administer the drug via routes other than injection. A large majority of individuals dependent on methamphetamine are poly-drug users.

Treatment for methamphetamine addiction has been demonstrated to be effective in reducing arrests, convictions, and health care costs.¹

¹ Nordlund, D., et al., *Treatment of Stimulant Addiction Including Addiction to Methamphetamine Results in Lower Health Care Costs and Reduced Arrests and Convictions: Washington State Supplemental Security Income Recipients*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

The Waiting List in Washington State for Treatment Under the Alcohol and Drug Abuse Treatment and Support Act Has Quadrupled Since 1991.



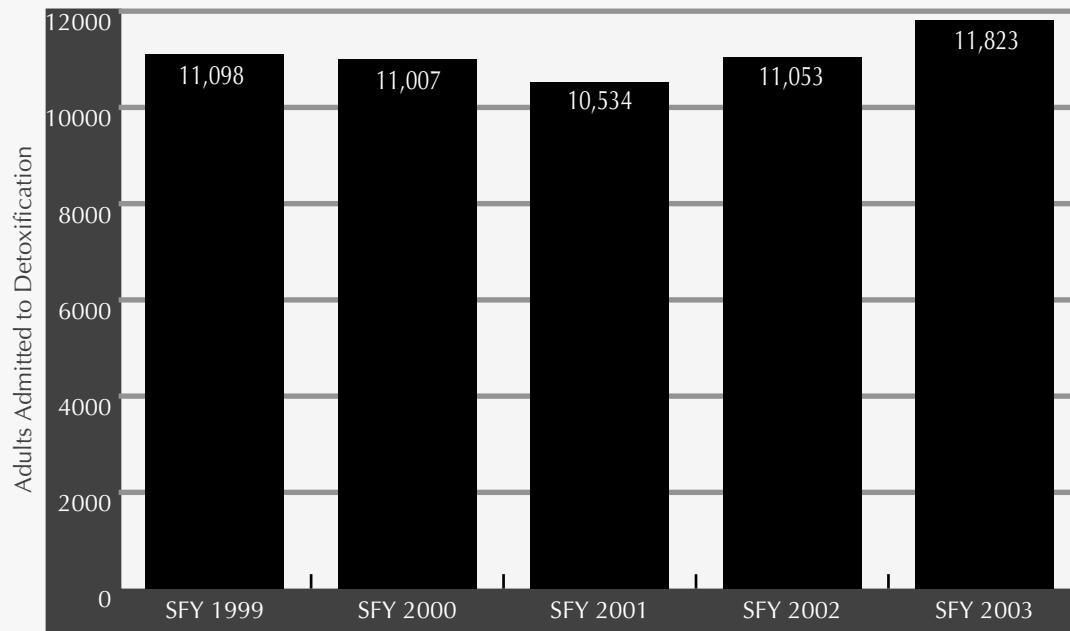
Source: Washington State Division of Alcohol and Substance Abuse, April 2004.

In 1989, the Washington State Legislature recognized in statute that, “alcoholism and drug addiction are treatable diseases, and that most persons with this illness can recover” (RCW 74.50.011). Under the Alcohol and Drug Abuse Treatment and Support Act (ADATSA), assessment, treatment, and support services are provided for individuals who are incapacitated from receipt of gainful employment and meet specific eligibility requirements.

The waiting list for ADATSA treatment services has quadrupled since 1991, and its growth is accelerating. Some of this growth is attributable to increased emphasis on treatment completion and retention, which has been shown to result in better outcomes. However, as of the second quarter of SFY, 2004, 47% of ADATSA clients already assessed as needing treatment are never admitted to treatment at all.



The Number of Adult Admissions to DASA-Funded Detoxification Has Remained Relatively Stable.

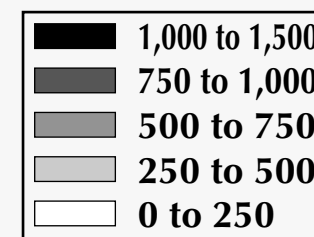
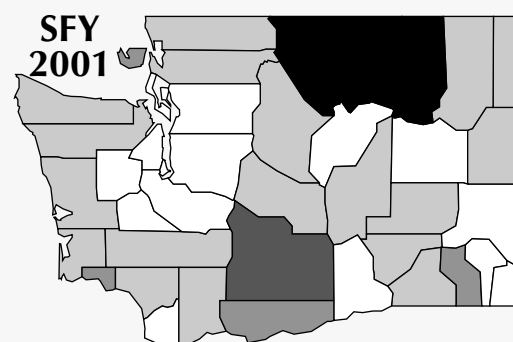
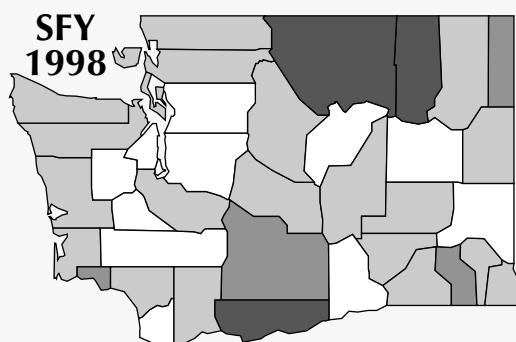


Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

This graph indicates that the number of adult admissions to DASA-funded detoxification services has remained relatively steady. There has been a significant increase in the number of DASA-funded detoxifications for methamphetamine, from 372 in SFY 1999, to 832 in SFY 2003, representing a 124% increase.

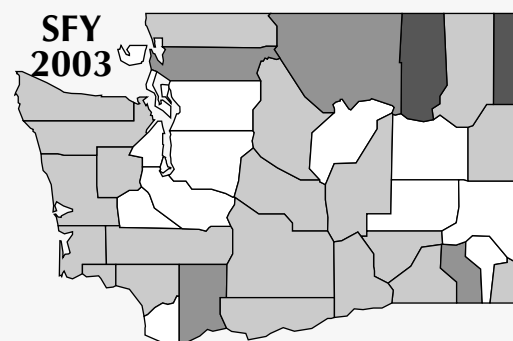
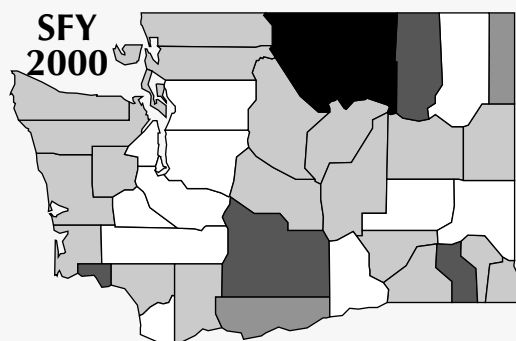
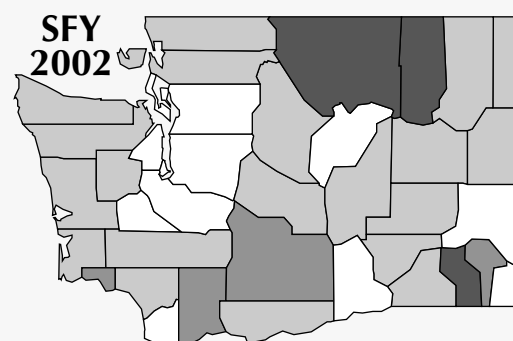
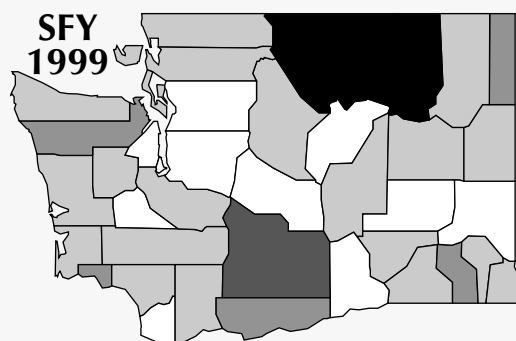
Detoxification is part of the array of services available to people in crisis, and is often a necessary precursor to chemical dependency treatment.

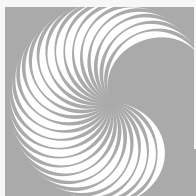
Washington State Adult Treatment Admissions for Alcohol Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service



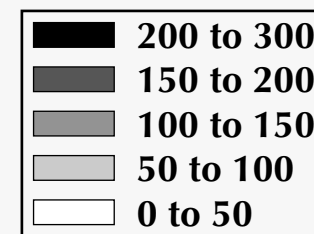
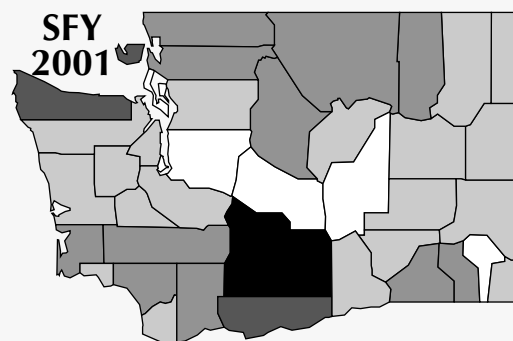
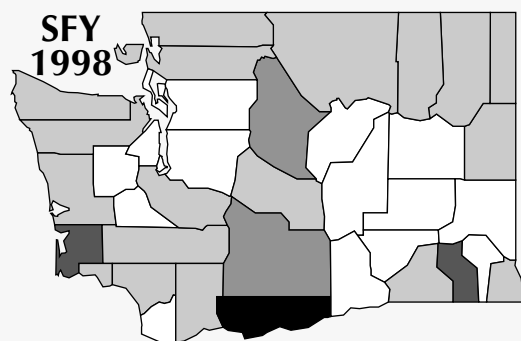


Washington State Adult Treatment Admissions* Primary Drug = Alcohol

County Name	SFY 1998		SFY 1999		SFY 2000		SFY 2001		SFY 2002		SFY 2003	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	41	254.8	39	240.9	30	182.6	43	259.0	55	331.1	32	192.8
Asotin	72	346.4	64	310.5	63	306.6	49	236.7	23	111.1	55	267.0
Benton	261	189.3	322	229.3	300	210.6	309	213.4	354	239.8	404	266.5
Chelan	282	424.6	279	417.0	310	465.4	259	386.0	232	343.2	218	321.1
Clallam	257	405.1	261	405.5	268	415.3	319	492.3	236	363.6	270	413.5
Clark	704	214.8	600	177.7	629	182.2	718	203.6	649	178.6	551	148.0
Columbia	27	602.1	32	749.1	32	787.4	24	585.4	33	804.9	27	658.5
Cowlitz	270	294.7	366	394.8	425	457.2	440	468.6	384	406.8	358	377.2
Douglas	62	193.5	71	218.3	85	260.7	74	225.6	57	172.2	59	175.6
Ferry	62	880.4	100	1,375.3	69	950.4	79	1,082.2	60	821.9	81	1,109.6
Franklin	177	370.7	174	360.2	171	346.5	178	353.2	196	382.1	181	337.7
Garfield	8	351.0	9	376.9	7	292.0	1	41.7	12	500.0	2	83.3
Grant	251	347.3	186	252.9	205	274.4	209	275.4	235	307.6	237	307.4
Grays Harbor	267	395.0	274	406.8	237	352.7	217	316.8	214	312.9	221	321.2
Island	185	265.8	197	279.4	207	289.3	151	208.6	153	209.3	147	198.6
Jefferson	86	337.9	143	557.2	87	335.2	80	306.5	71	266.9	83	310.9
King	3664	215.3	4238	246.4	3929	226.2	3351	190.6	3,100	174.7	2,482	139.5
Kitsap	346	150.5	395	172.1	373	160.8	374	160.2	559	238.2	557	235.0
Kittitas	95	294.0	85	246.1	98	293.7	113	332.4	103	296.0	143	406.2
Klickitat	160	867.0	101	537.4	135	704.6	113	585.5	80	414.5	51	264.2
Lewis	155	228.2	183	267.0	149	217.2	168	241.7	210	299.1	184	261.4
Lincoln	24	238.1	29	285.9	46	451.7	29	284.3	26	254.9	22	217.8
Mason	98	204.5	149	307.1	182	368.4	122	246.0	141	283.1	180	358.6
Okanogan	377	956.2	496	1,258.0	452	1,142.5	457	1,151.1	314	788.9	289	729.8
Pacific	72	344.0	57	271.7	75	357.4	62	295.2	99	471.4	81	387.6
Pend Oreille	64	540.2	80	686.5	81	690.4	58	491.5	54	457.6	95	805.1
Pierce	1869	274.7	1940	280.5	1495	213.3	1457	204.2	1,290	177.9	1,185	161.5
San Juan	51	385.2	51	363.8	53	376.5	74	513.9	50	342.5	34	229.7
Skagit	479	479.7	470	460.5	460	446.7	484	464.9	356	338.7	567	531.4
Skamania	32	334.7	29	302.6	33	334.3	30	303.0	57	575.8	57	575.8
Snohomish	1168	202.7	1437	242.9	1491	246.0	1477	238.8	1,018	162.1	1,239	194.4
Spokane	1083	261.9	1138	273.1	1214	290.5	1317	311.8	1,116	262.2	1,290	301.0
Stevens	114	299.0	118	304.4	97	242.1	112	277.9	131	324.3	140	344.8
Thurston	384	189.7	353	171.7	410	197.7	392	186.5	457	215.3	421	196.0
Wahkiakum	22	566.3	23	593.5	36	941.4	25	657.9	23	605.3	27	710.5
Walla Walla	169	304.4	184	333.9	171	309.9	184	333.3	146	263.5	219	392.5
Whatcom	703	438.8	777	473.0	782	468.8	815	477.7	736	427.4	597	342.1
Whitman	62	151.0	68	165.1	79	193.9	71	176.2	55	135.5	82	200.0
Yakima	1521	682.6	1998	893.6	1904	855.4	1959	872.6	1,472	654.2	1,322	585.0
Total	15,724	273.5	17,516	300.4	16,870	286.2	16,394	274.4	14,557	240.9	14,190	232.7

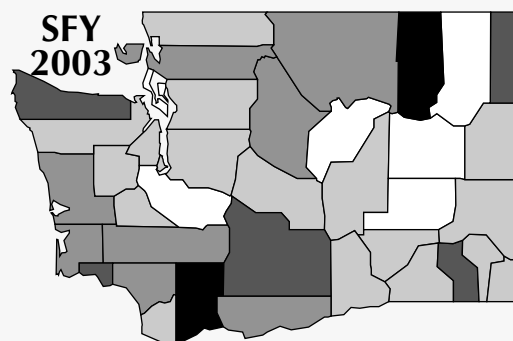
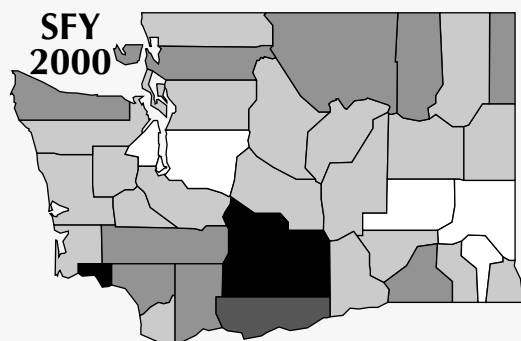
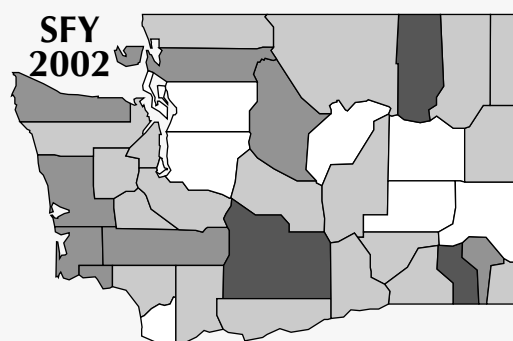
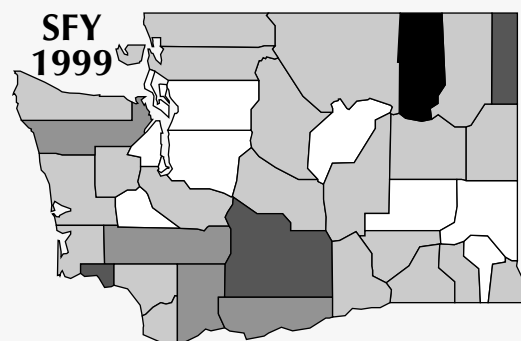
*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

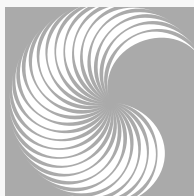
Washington State Adult Treatment Admissions for Marijuana Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service



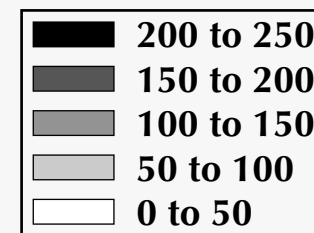
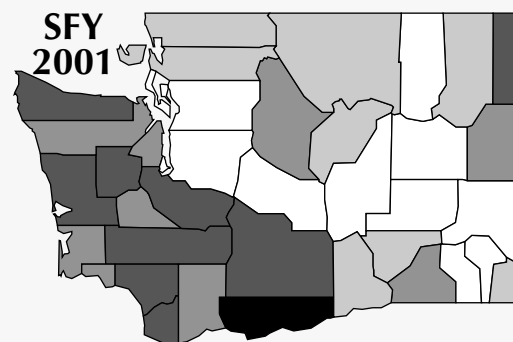
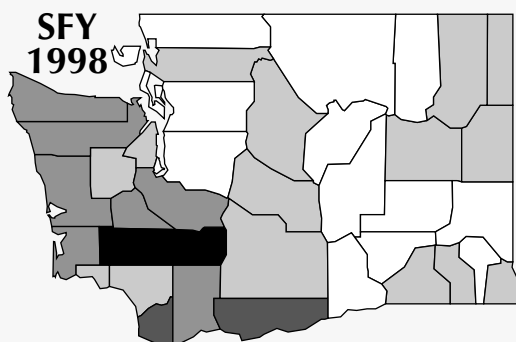


Washington State Adult Treatment Admissions* Primary Drug = Marijuana

County Name	SFY 1998		SFY 1999		SFY 2000		SFY 2001		SFY 2002		SFY 2003	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	2	12.4	1	6.2	2	12.2	9	54.2	2	12.0	3	18.1
Asotin	15	72.2	12	58.2	13	63.3	14	67.6	18	87.0	15	72.8
Benton	66	47.9	93	66.2	86	60.4	121	83.6	111	75.2	114	75.2
Chelan	69	103.9	62	92.7	50	75.1	77	114.8	68	100.6	82	120.8
Clallam	52	82.0	73	113.4	91	141.0	125	192.9	80	123.3	107	163.9
Clark	155	47.3	210	62.2	194	56.2	307	87.1	214	58.9	195	52.4
Columbia	7	156.1	3	70.2	4	98.4	5	122.0	7	170.7	7	170.7
Cowlitz	72	78.6	67	72.3	106	114.0	100	106.5	81	85.8	113	119.1
Douglas	7	21.8	14	43.0	18	55.2	17	51.8	12	36.3	15	44.6
Ferry	7	99.4	16	220.1	9	124.0	9	123.3	11	150.7	16	219.2
Franklin	18	37.7	32	66.2	26	52.7	31	61.5	43	83.8	40	74.6
Garfield	0	0.0	0	0.0	0	0.0	1	41.7	3	125.0	2	83.3
Grant	33	45.7	38	51.7	42	56.2	28	36.9	56	73.3	52	67.4
Grays Harbor	53	78.4	56	83.1	47	69.9	51	74.5	77	112.6	87	126.5
Island	25	35.9	28	39.7	49	68.5	28	38.7	25	34.2	35	47.3
Jefferson	27	106.1	27	105.2	22	84.8	26	99.6	21	78.9	25	93.6
King	492	28.9	644	37.4	741	42.7	761	43.3	611	34.4	512	28.8
Kitsap	90	39.2	105	45.7	92	39.7	129	55.3	148	63.1	155	65.4
Kittitas	23	71.2	18	52.1	27	80.9	16	47.1	19	54.6	23	65.3
Klickitat	39	211.3	27	143.7	30	156.6	35	181.3	15	77.7	21	108.8
Lewis	40	58.9	74	108.0	76	110.8	72	103.6	55	78.3	82	116.5
Lincoln	5	49.6	6	59.1	6	58.9	7	68.6	3	29.4	5	49.5
Mason	15	31.3	26	53.6	46	93.1	45	90.7	25	50.2	50	99.6
Okanogan	24	60.9	25	63.4	45	113.7	51	128.5	38	95.5	52	131.3
Pacific	33	157.7	20	95.3	19	90.5	25	119.0	21	100.0	26	124.4
Pend Oreille	11	92.8	21	180.2	17	144.9	9	76.3	11	93.2	23	194.9
Pierce	424	62.3	546	79.0	578	82.5	591	82.8	426	58.8	442	60.2
San Juan	10	75.5	8	57.1	15	106.6	26	180.6	16	109.6	15	101.4
Skagit	74	74.1	100	98.0	119	115.6	128	123.0	116	110.4	129	120.9
Skamania	8	83.7	11	114.8	12	121.6	12	121.2	8	80.8	20	202.0
Snohomish	200	34.7	258	43.6	383	63.2	387	62.6	265	42.2	329	51.6
Spokane	230	55.6	308	73.9	373	89.2	397	94.0	264	62.0	250	58.3
Stevens	31	81.3	26	67.1	30	74.9	30	74.4	29	71.8	25	61.6
Thurston	75	37.1	92	44.8	135	65.1	138	65.7	174	82.0	189	88.0
Wahkiakum	3	77.2	7	180.6	8	209.2	3	78.9	4	105.3	7	184.2
Walla Walla	36	64.8	41	74.4	60	108.7	72	130.4	28	50.5	50	89.6
Whatcom	99	61.8	123	74.9	116	69.5	177	103.8	172	99.9	140	80.2
Whitman	11	26.8	9	21.8	14	34.4	25	62.0	14	34.5	22	53.7
Yakima	326	146.3	446	199.5	497	223.3	562	250.3	447	198.7	358	158.4
Total	2,907	50.6	3,673	63.0	4,198	71.2	4,647	77.8	3,738	61.9	3,833	62.9

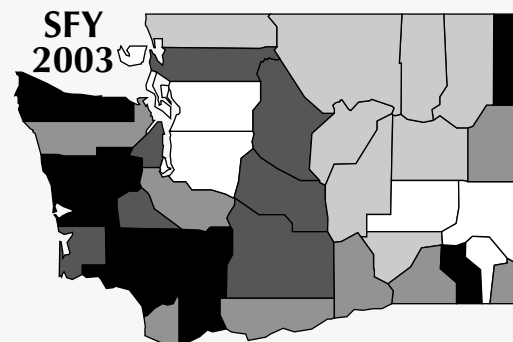
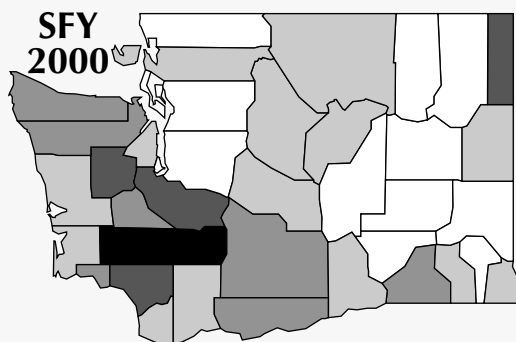
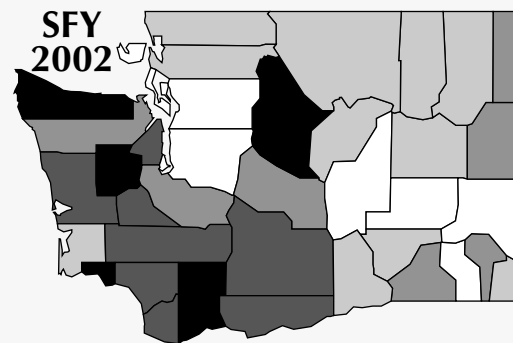
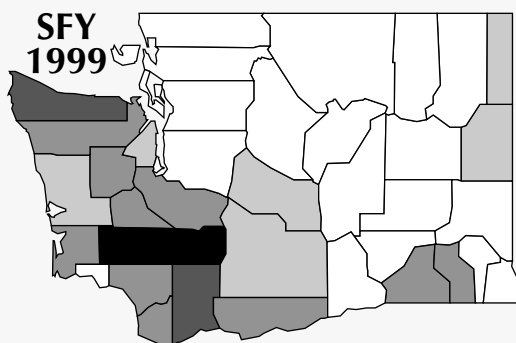
*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

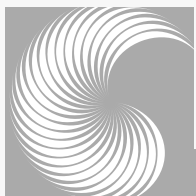
Washington State Adult Treatment Admissions for Methamphetamine Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service



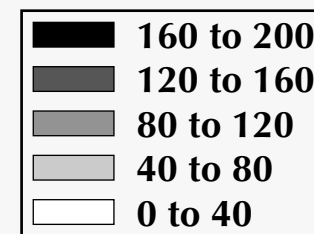
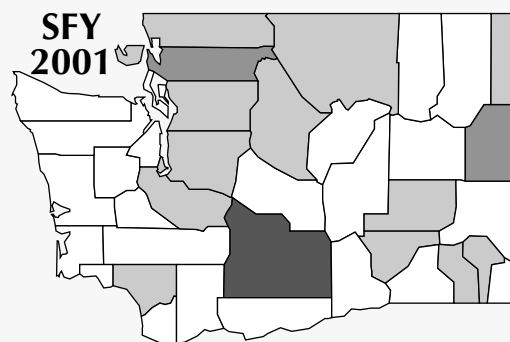
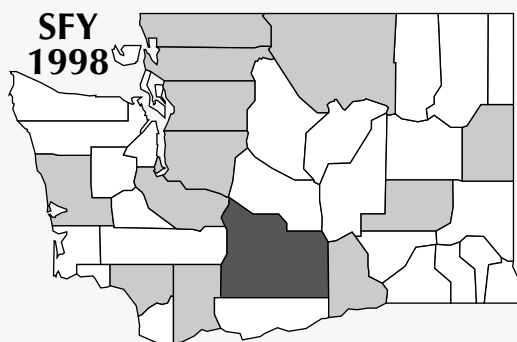


Washington State Adult Treatment Admissions* Primary Drug = Methamphetamine

County Name	SFY 1998		SFY 1999		SFY 2000		SFY 2001		SFY 2002		SFY 2003	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	4	24.9	1	6.2	3	18.3	0	0.0	5	30.1	1	6.0
Asotin	17	81.8	10	48.5	16	77.9	20	96.6	21	101.4	25	121.4
Benton	55	39.9	69	49.1	87	61.1	131	90.5	165	111.8	156	102.9
Chelan	35	52.7	20	29.9	44	66.1	75	111.8	137	202.7	105	154.6
Clallam	72	113.5	100	155.4	91	141.0	105	162.0	152	234.2	204	312.4
Clark	546	166.6	478	141.6	493	142.8	679	192.6	576	158.5	542	145.6
Columbia	3	66.9	5	117.0	3	73.8	2	48.8	1	24.4	12	292.7
Cowlitz	71	77.5	130	140.2	169	181.8	181	192.8	185	196.0	261	275.0
Douglas	13	40.6	13	40.0	22	67.5	22	67.1	33	99.7	31	92.3
Ferry	0	0.0	0	0.0	0	0.0	3	41.1	5	68.5	7	95.9
Franklin	9	18.8	23	47.6	18	36.5	36	71.4	29	56.5	48	89.6
Garfield	0	0.0	1	41.9	0	0.0	0	0.0	4	166.7	1	41.7
Grant	14	19.4	11	15.0	12	16.1	22	29.0	36	47.1	67	86.9
Grays Harbor	86	127.2	56	83.1	59	87.8	105	153.3	126	184.2	149	216.6
Island	16	23.0	13	18.4	20	27.9	34	47.0	32	43.8	29	39.2
Jefferson	31	121.8	38	148.1	32	123.3	32	122.6	28	105.3	28	104.9
King	363	21.3	397	23.1	454	26.1	580	33.0	659	37.1	488	27.4
Kitsap	196	85.3	178	77.5	206	88.8	271	116.1	363	154.7	406	171.3
Kittitas	23	71.2	21	60.8	30	89.9	14	41.2	43	123.6	53	150.6
Klickitat	32	173.4	24	127.7	21	109.6	48	248.7	34	176.2	21	108.8
Lewis	137	201.7	168	245.1	152	221.6	118	169.8	136	193.7	180	255.7
Lincoln	6	59.5	1	9.9	3	29.5	2	19.6	10	98.0	7	69.3
Mason	31	64.7	55	113.4	75	151.8	88	177.4	108	216.9	116	231.1
Okanogan	11	27.9	12	30.4	20	50.6	24	60.5	21	52.8	23	58.1
Pacific	22	105.1	22	104.9	11	52.4	26	123.8	33	157.1	34	162.7
Pend Oreille	10	84.4	8	68.6	22	187.5	19	161.0	13	110.2	34	288.1
Pierce	798	117.3	969	140.1	1108	158.1	1272	178.3	1079	148.8	889	121.2
San Juan	4	30.2	4	28.5	8	56.8	8	55.6	7	47.9	6	40.5
Skagit	64	64.1	41	40.2	72	69.9	99	95.1	103	98.0	190	178.1
Skamania	13	136.0	16	166.9	8	81.0	11	111.1	42	424.2	28	282.8
Snohomish	181	31.4	212	35.8	244	40.3	279	45.1	301	47.9	370	58.0
Spokane	227	54.9	294	70.6	372	89.0	522	123.6	462	108.6	557	130.0
Stevens	21	55.1	19	49.0	19	47.4	23	57.1	23	56.9	31	76.4
Thurston	245	121.1	209	101.7	222	107.1	265	126.1	342	161.1	327	152.2
Wahkiakum	3	77.2	1	25.8	5	130.8	5	131.6	10	263.2	12	315.8
Walla Walla	55	99.1	60	108.9	68	123.2	59	106.9	66	119.1	70	125.4
Whatcom	30	18.7	50	30.4	74	44.4	92	53.9	142	82.5	117	67.0
Whitman	8	19.5	7	17.0	6	14.7	10	24.8	19	46.8	10	24.4
Yakima	165	74.0	219	97.9	241	108.3	418	186.2	379	168.4	359	158.8
Total	3,617	62.9	3,955	67.8	4,510	76.5	5,700	95.4	5,930	98.2	5,994	98.3

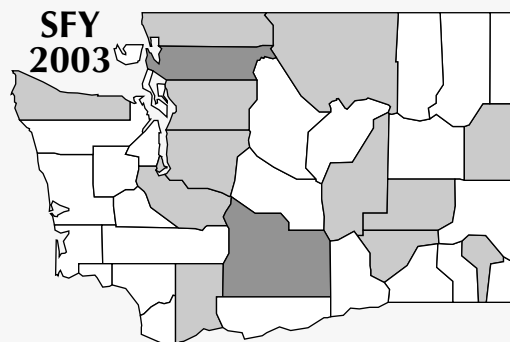
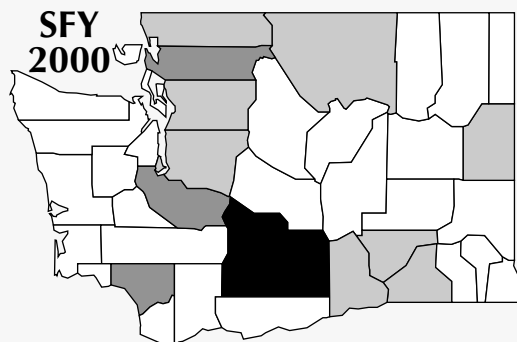
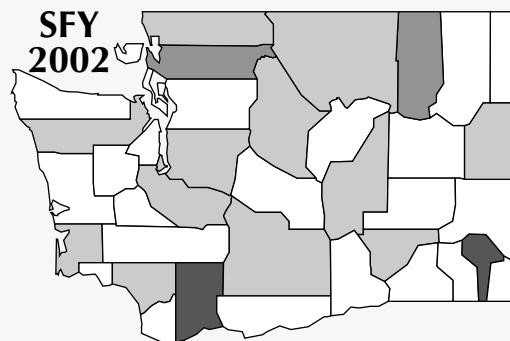
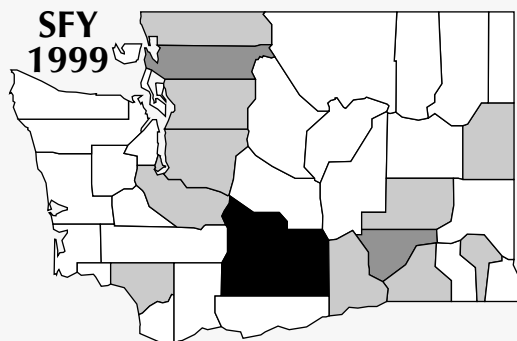
*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

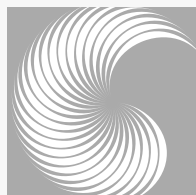
Washington State Adult Treatment Admissions for Cocaine Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service



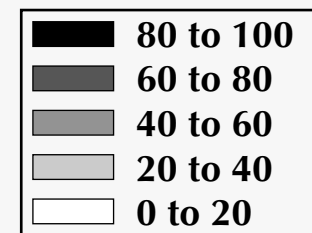
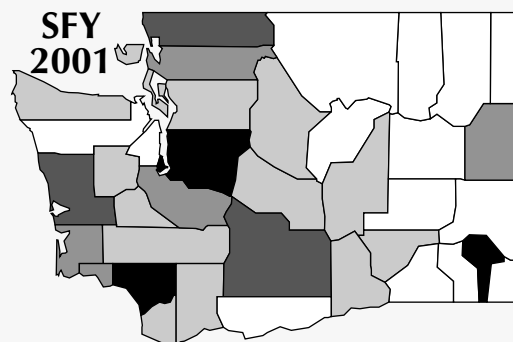
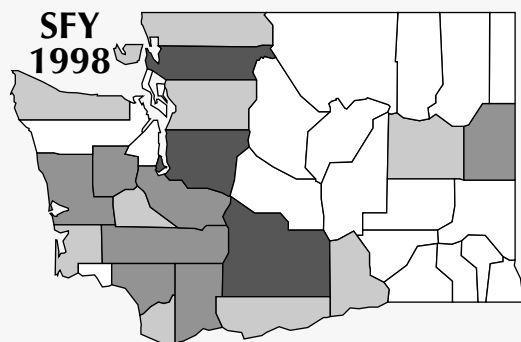


Washington State Adult Treatment Admissions* Primary Drug = Cocaine

County Name	SFY 1998		SFY 1999		SFY 2000		SFY 2001		SFY 2002		SFY 2003	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	10	62.1	8	49.4	6	36.5	8	48.2	4	24.1	8	48.2
Asotin	1	4.8	3	14.6	2	9.7	1	4.8	0	0.0	0	0.0
Benton	37	26.8	77	54.8	57	40.0	53	36.6	46	31.2	37	24.4
Chelan	29	43.7	18	26.9	21	31.5	27	40.2	28	41.4	27	39.8
Clallam	10	15.8	20	31.1	14	21.7	16	24.7	14	21.6	32	49.0
Clark	128	39.0	117	34.7	84	24.3	109	30.9	116	31.9	88	23.6
Columbia	1	22.3	0	0.0	1	24.6	2	48.8	0	0.0	1	24.4
Cowlitz	55	60.0	46	49.6	83	89.3	71	75.6	51	54.0	33	34.8
Douglas	5	15.6	4	12.3	12	36.8	7	21.3	6	18.1	8	23.8
Ferry	1	14.2	1	13.8	1	13.8	0	0.0	6	82.2	1	13.7
Franklin	15	31.4	43	89.0	31	62.8	33	65.5	30	58.5	30	56.0
Garfield	0	0.0	1	41.9	0	0.0	1	41.7	3	125.0	1	41.7
Grant	26	36.0	21	28.6	28	37.5	20	26.4	40	52.4	38	49.3
Grays Harbor	39	57.7	25	37.1	16	23.8	20	29.2	7	10.2	16	23.3
Island	12	17.2	15	21.3	13	18.2	10	13.8	10	13.7	13	17.6
Jefferson	3	11.8	2	7.8	1	3.9	3	11.5	11	41.4	7	26.2
King	1138	66.9	1372	79.8	1386	79.8	1223	69.6	974	54.9	895	50.3
Kitsap	44	19.1	47	20.5	53	22.8	53	22.7	61	26.0	69	29.1
Kittitas	3	9.3	2	5.8	7	21.0	4	11.8	5	14.4	9	25.6
Klickitat	6	32.5	2	10.6	4	20.9	3	15.5	1	5.2	1	5.2
Lewis	8	11.8	6	8.8	10	14.6	3	4.3	2	2.8	4	5.7
Lincoln	1	9.9	3	29.6	1	9.8	1	9.8	1	9.8	0	0.0
Mason	11	23.0	13	26.8	11	22.3	14	28.2	8	16.1	9	17.9
Okanogan	21	53.3	10	25.4	19	48.0	23	57.9	17	42.7	24	60.6
Pacific	6	28.7	5	23.8	5	23.8	4	19.0	12	57.1	6	28.7
Pend Oreille	3	25.3	1	8.6	2	17.0	6	50.8	2	16.9	3	25.4
Pierce	521	76.6	641	92.7	577	82.3	514	72.0	416	57.4	418	57.0
San Juan	0	0.0	0	0.0	3	21.3	9	62.5	5	34.2	3	20.3
Skagit	69	69.1	111	108.7	119	115.6	98	94.1	88	83.7	116	108.7
Skamania	4	41.8	1	10.4	1	10.1	2	20.2	15	151.5	5	50.5
Snohomish	350	60.7	377	63.7	355	58.6	351	56.7	243	38.7	273	42.8
Spokane	242	58.5	296	71.0	301	72.0	348	82.4	238	55.9	316	73.7
Stevens	2	5.2	6	15.5	9	22.5	4	9.9	8	19.8	12	29.6
Thurston	33	16.3	53	25.8	56	27.0	45	21.4	59	27.8	42	19.6
Wahkiakum	0	0.0	0	0.0	1	26.2	0	0.0	0	0.0	1	26.3
Walla Walla	12	21.6	25	45.4	23	41.7	16	29.0	8	14.4	12	21.5
Whatcom	87	54.3	81	49.3	99	59.3	105	61.5	87	50.5	119	68.2
Whitman	1	2.4	1	2.4	2	4.9	9	22.3	8	19.7	7	17.1
Yakima	297	133.3	400	178.9	365	164.0	359	159.9	280	124.4	229	101.3
Total	3,231	56.2	3,854	66.1	3,779	64.1	3,575	59.8	2,910	48.2	2,913	47.8

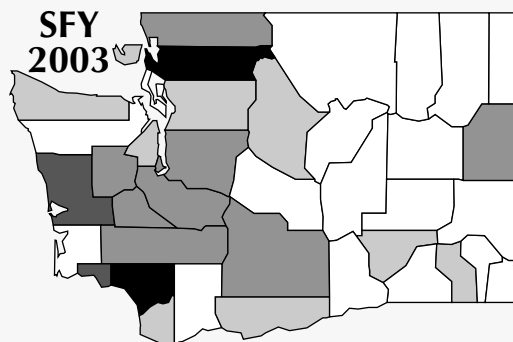
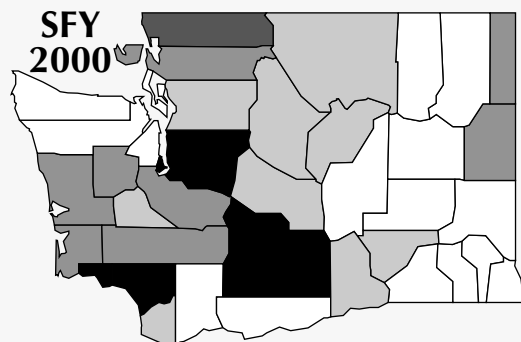
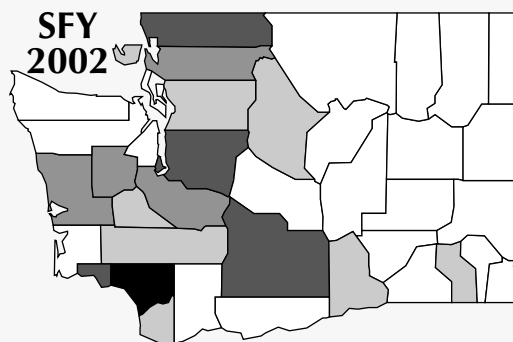
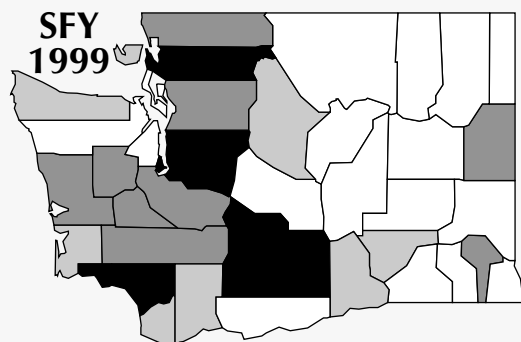
*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

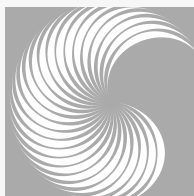
Washington State Adult Treatment Admissions for Heroin Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service





Washington State Adult Treatment Admissions* Primary Drug = Heroin

County Name	SFY 1998		SFY 1999		SFY 2000		SFY 2001		SFY 2002		SFY 2003	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	0	0.0	2	12.4	1	6.1	2	12.0	1	6.0	0	0.0
Asotin	4	19.2	2	9.7	3	14.6	4	19.3	0	0.0	1	4.9
Benton	47	34.1	55	39.2	33	23.2	34	23.5	31	21.0	22	14.5
Chelan	11	16.6	15	22.4	23	34.5	25	37.3	16	23.7	15	22.1
Clallam	19	29.9	20	31.1	12	18.6	14	21.6	8	12.3	16	24.5
Clark	130	39.7	118	35.0	113	32.7	125	35.5	131	36.0	112	30.1
Columbia	0	0.0	0	0.0	0	0.0	0	0.0	1	24.4	1	24.4
Cowlitz	53	57.9	86	92.8	158	170.0	93	99.0	89	94.3	91	95.9
Douglas	7	21.8	3	9.2	8	24.5	5	15.2	4	12.1	4	11.9
Ferry	1	14.2	0	0.0	1	13.8	0	0.0	0	0.0	0	0.0
Franklin	9	18.8	16	33.1	16	32.4	16	31.7	9	17.5	14	26.1
Garfield	0	0.0	1	41.9	0	0.0	2	83.3	0	0.0	0	0.0
Grant	11	15.2	10	13.6	8	10.7	22	29.0	5	6.5	12	15.6
Grays Harbor	29	42.9	33	49.0	39	58.0	45	65.7	31	45.3	55	79.9
Island	8	11.5	11	15.6	8	11.2	16	22.1	5	6.8	2	2.7
Jefferson	2	7.9	5	19.5	2	7.7	4	15.3	2	7.5	2	7.5
King	1322	77.7	1382	80.3	1807	104.0	1406	80.0	1200	67.7	783	44.0
Kitsap	35	15.2	34	14.8	28	12.1	27	11.6	37	15.8	56	23.6
Kittitas	3	9.3	3	8.7	9	27.0	8	23.5	3	8.6	2	5.7
Klickitat	4	21.7	2	10.6	2	10.4	2	10.4	0	0.0	6	31.1
Lewis	34	50.1	38	55.4	30	43.7	17	24.5	20	28.5	36	51.1
Lincoln	3	29.8	1	9.9	1	9.8	0	0.0	1	9.8	1	9.9
Mason	24	50.1	25	51.5	27	54.7	19	38.3	22	44.2	32	63.7
Okanogan	5	12.7	1	2.5	8	20.2	3	7.6	2	5.0	3	7.6
Pacific	5	23.9	8	38.1	11	52.4	11	52.4	4	19.0	4	19.1
Pend Oreille	1	8.4	1	8.6	5	42.6	1	8.5	0	0.0	2	16.9
Pierce	405	59.5	396	57.3	342	48.8	414	58.0	367	50.6	321	43.8
San Juan	4	30.2	4	28.5	7	49.7	5	34.7	4	27.4	3	20.3
Skagit	68	68.1	92	90.1	60	58.3	55	52.8	46	43.8	93	87.2
Skamania	5	52.3	2	20.9	0	0.0	3	30.3	1	10.1	0	0.0
Snohomish	159	27.6	272	46.0	230	38.0	195	31.5	151	24.0	142	22.3
Spokane	207	50.1	201	48.2	246	58.9	223	52.8	174	40.9	203	47.4
Stevens	2	5.2	3	7.7	4	10.0	3	7.4	4	9.9	1	2.5
Thurston	76	37.6	108	52.5	71	34.2	78	37.1	83	39.1	120	55.9
Wahkiakum	0	0.0	5	129.0	6	156.9	2	52.6	3	78.9	3	78.9
Walla Walla	4	7.2	9	16.3	9	16.3	6	10.9	4	7.2	9	16.1
Whatcom	74	46.2	71	43.2	114	68.3	123	72.1	120	69.7	93	53.3
Whitman	0	0.0	2	4.9	0	0.0	0	0.0	0	0.0	8	19.5
Yakima	175	78.5	195	87.2	222	99.7	164	73.1	176	78.2	122	54.0
Total	2,946	51.2	3,232	55.4	3,664	62.2	3,172	53.1	2,755	45.6	2,390	39.2

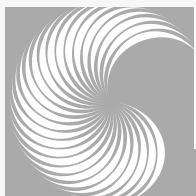
*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Treatment Admission Trends

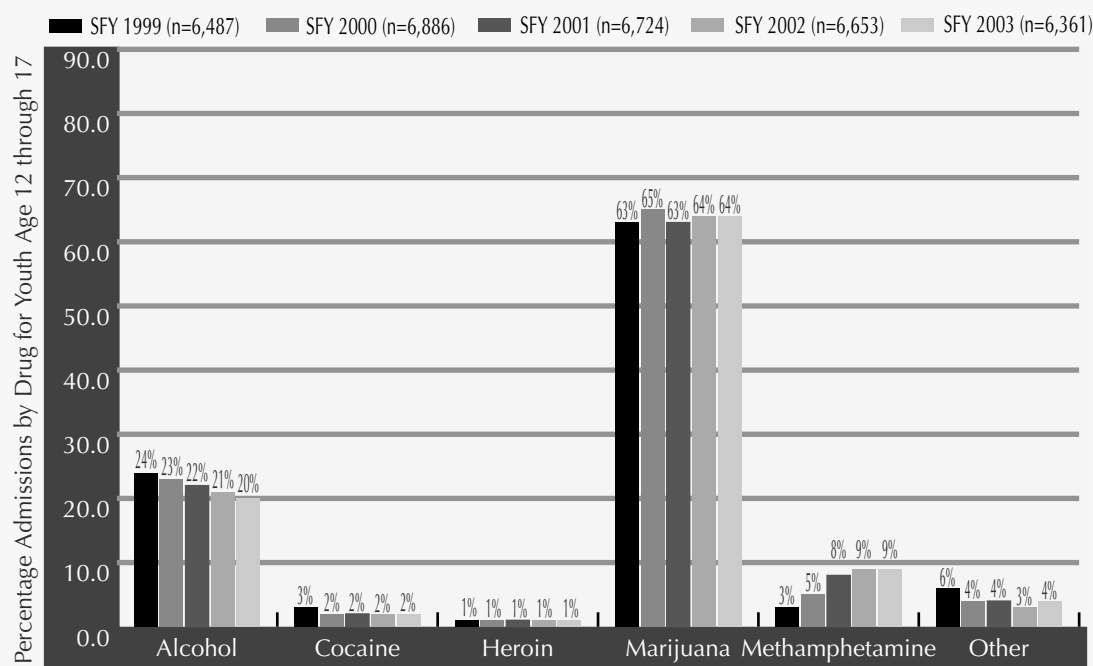
**Treatment
Admission**

Adult

Youth



Marijuana is the Most Frequently Cited Drug of Abuse in Youth Admissions to DASA-Funded Treatment.*



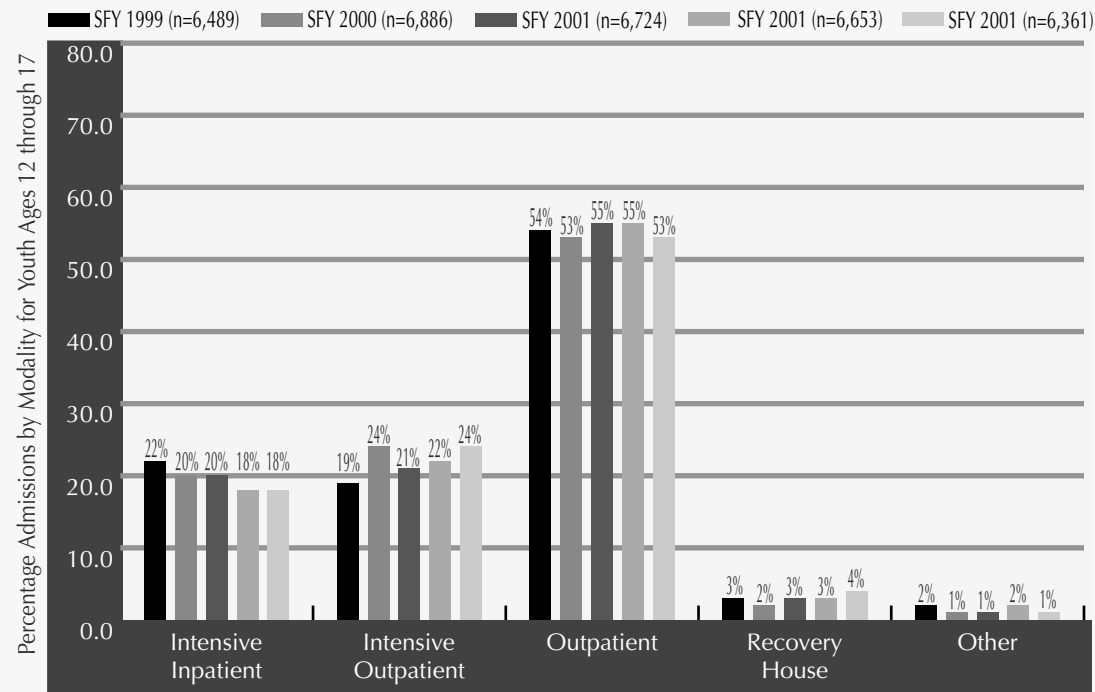
Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

This graph indicates that the majority of youth admissions to DASA-funded treatment are for marijuana. Youth admissions for methamphetamine abuse have almost tripled, from 201 in SFY 1999, to 591 in SFY 2003.

Note: Data may include multiple admissions for a single individual over the course of a year.

* Excludes detoxification and transitional housing.

The Majority of Youth Admissions to DASA-Funded Chemical Dependency Treatment are for Outpatient Services.*

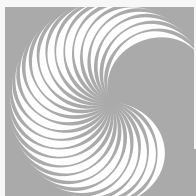


Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

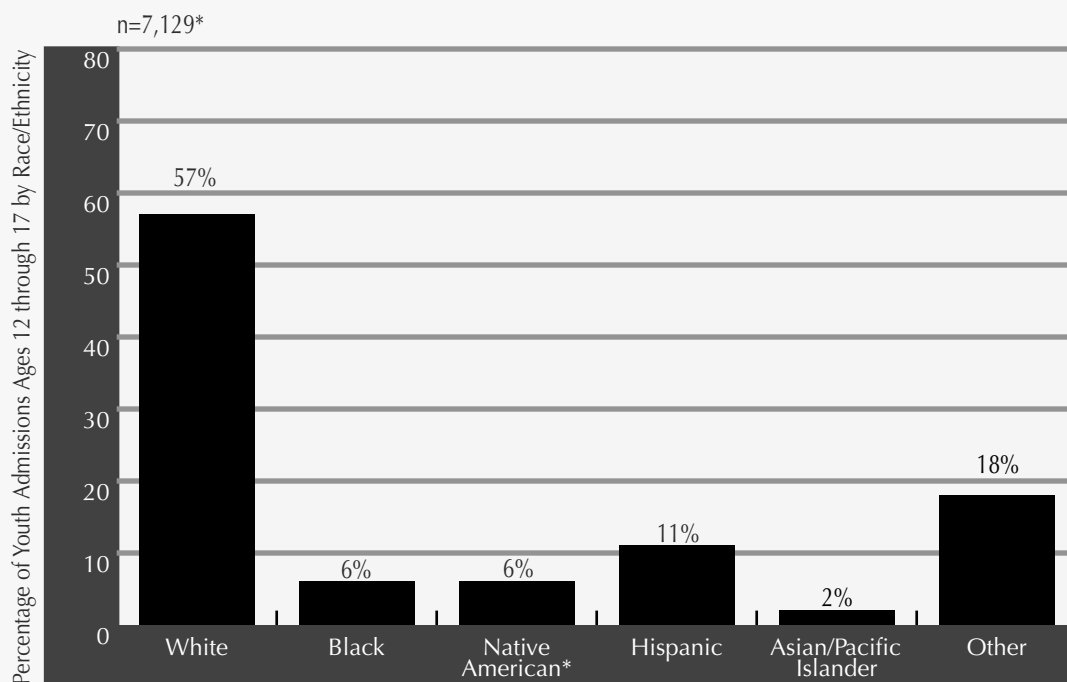
More than three quarters of youth admissions to DASA-funded chemical dependency treatment are for outpatient and intensive outpatient services.

Note: Data may include multiple admissions for a single individual over the course of a year. "Other" includes group care enhancement, recovery house, long-term residential, methadone, and treatment services for those with co-occurring disorders.

* Excludes detoxification and transitional housing.



Racial and Ethnic Minorities Comprise 43% of Youth Admissions to DASA-Funded Chemical Dependency Treatment Services.



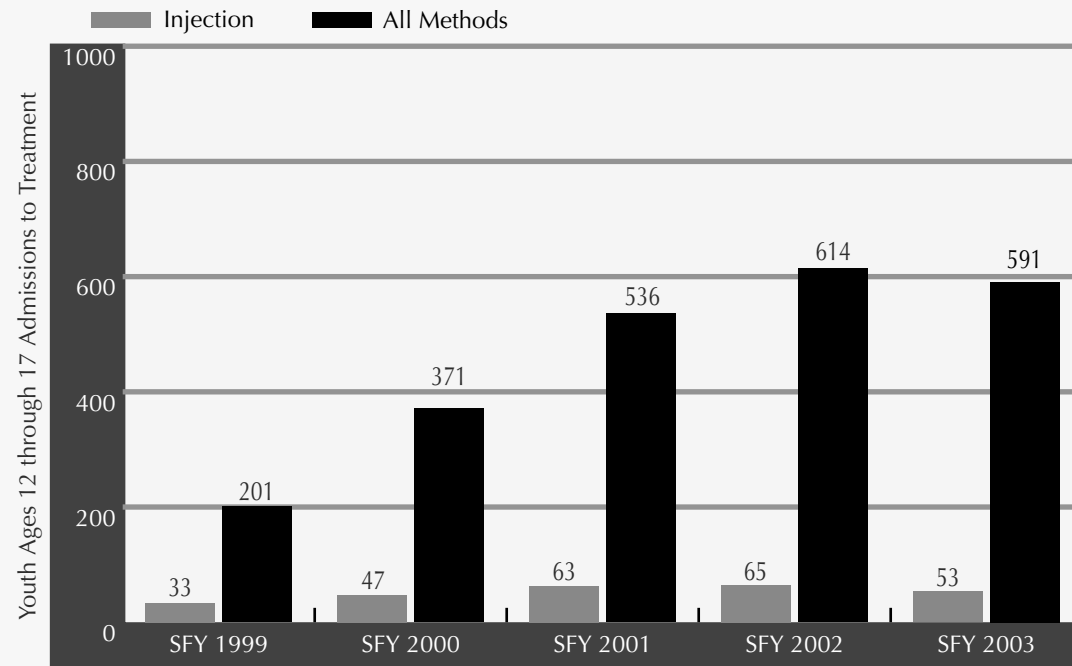
Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

This graph indicates that racial/ethnic minorities comprised approximately 43% of youth admissions to DASA-funded chemical dependency treatment in SFY 2003. Percentages of youth from different groups receiving DASA-funded treatment vary across modalities.

* In the U.S. Census, "Hispanic" is listed as an ethnicity, rather than as a racial group. Hence, Hispanic admissions may be duplication in the racial categories.

** Includes Eskimo/Alaskan Native/Aleut

DASA-Funded Youth Treatment Admissions for Methamphetamine Use Seem to Have Peaked.



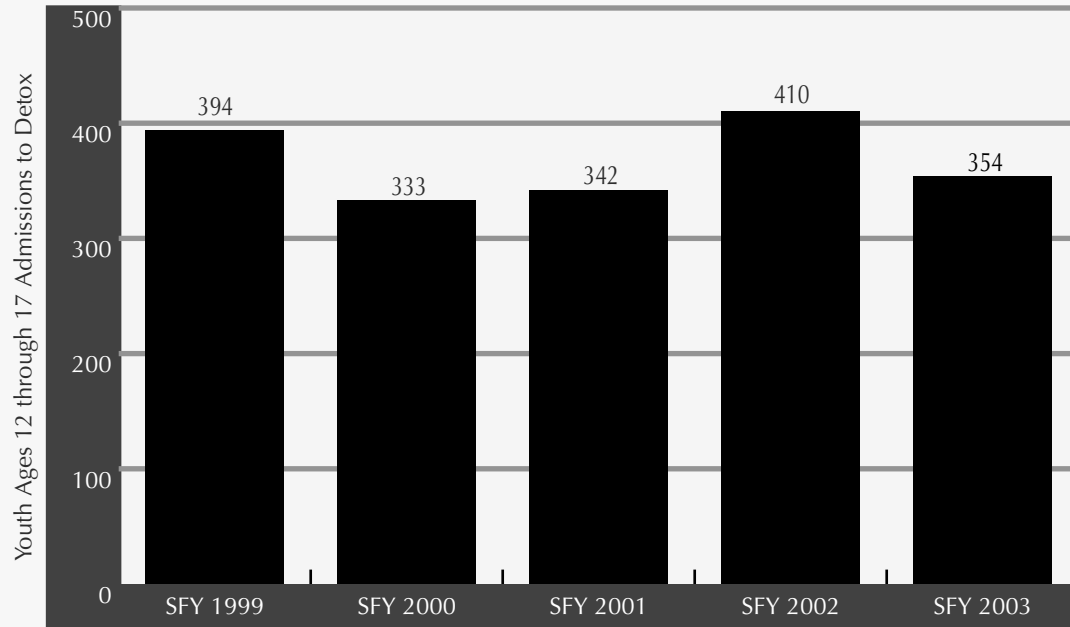
Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

DASA-funded youth treatment admissions for methamphetamine use appear to have peaked. However, youth admissions are now almost three times higher than they were in SFY 1999. Youth are far less likely to inject methamphetamine than adults.

Note: Data exclude detoxification and transitional housing, private-pay, and Department of Corrections admission; includes total unduplicated admissions within counties.



The Number of Youth Admissions to DASA-Funded Detoxification Has Remained Relatively Stable.

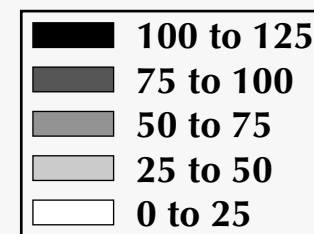
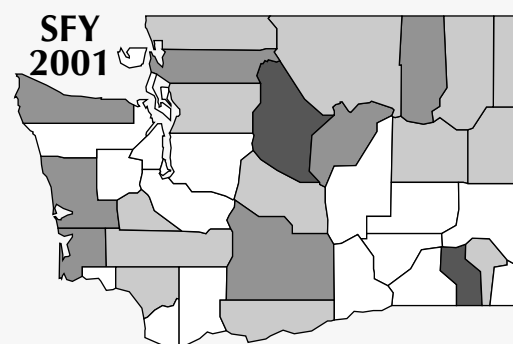
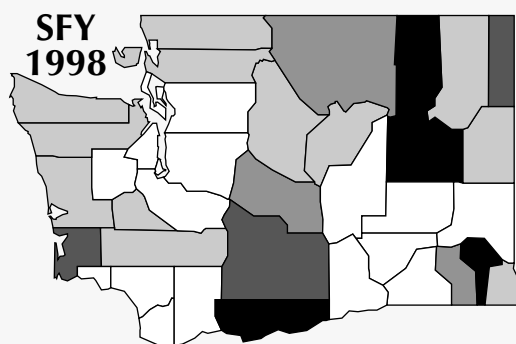


Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

This graph indicates that the number of youth admissions to DASA-funded detoxification services has remained relatively steady. A plurality of DASA-funded youth admissions to detoxification services are for marijuana (153 in SFY 2003).

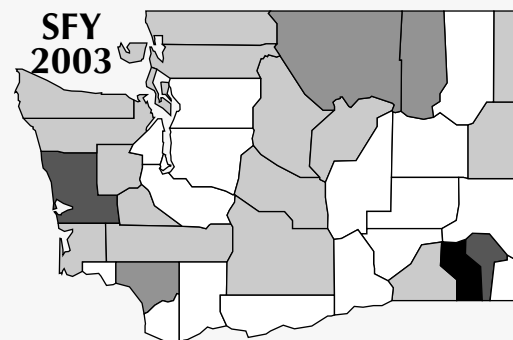
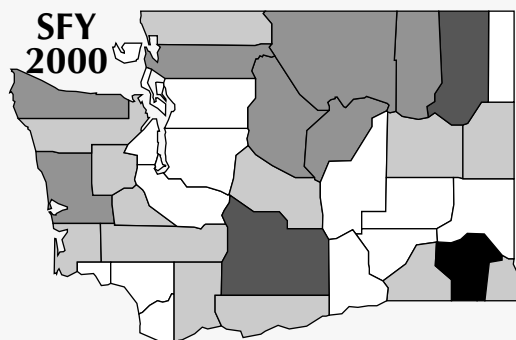
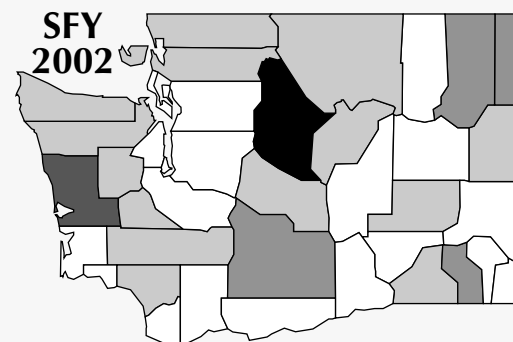
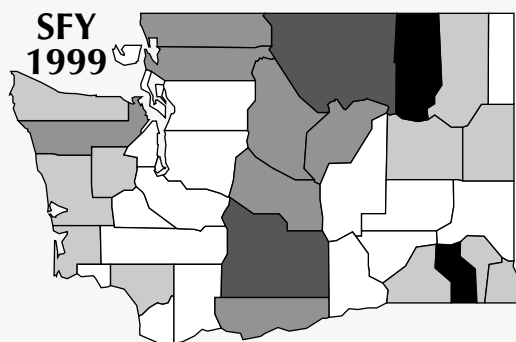
Detoxification is part of the array of services available to youth in crisis, and is often a necessary precursor to chemical dependency treatment.

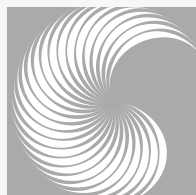
Washington State Youth Treatment Admissions for Alcohol Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service



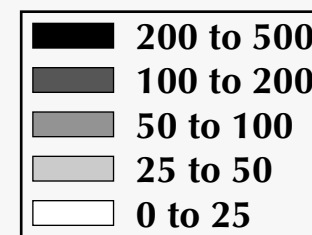
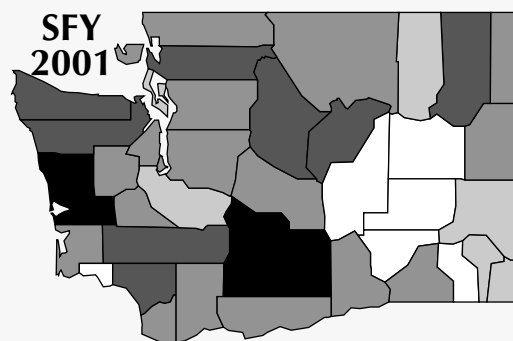
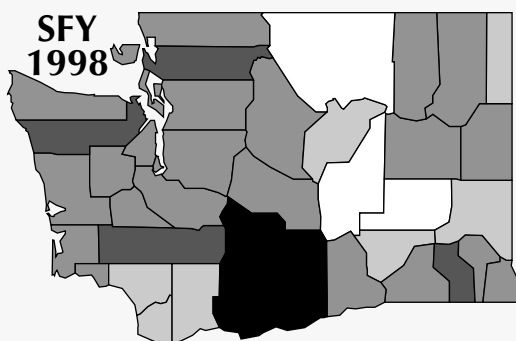


Washington State Youth Treatment Admissions * Primary Drug = Alcohol

County Name	SFY 1998		SFY 1999		SFY 2000		SFY 2001		SFY 2002		SFY 2003	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	3	18.6	1	6.2	3	18.3	2	12.0	5	30.1	2	12.0
Asotin	9	43.3	10	48.5	6	29.2	2	9.7	0	0.0	4	19.0
Benton	23	16.7	16	11.4	27	19.0	14	9.7	18	12.2	32	21.0
Chelan	23	34.6	48	71.7	45	67.6	64	95.4	77	113.9	32	47.0
Clallam	31	48.9	32	49.7	45	69.7	34	52.5	24	37.0	20	31.0
Clark	44	13.4	46	13.6	40	11.6	35	9.9	39	10.7	37	10.0
Columbia	3	66.9	6	140.4	5	123.0	4	97.6	3	73.2	10	244.0
Cowlitz	16	17.5	24	25.9	23	24.7	26	27.7	29	30.7	47	50.0
Douglas	9	28.1	22	67.6	18	55.2	18	54.9	14	42.3	12	36.0
Ferry	13	184.6	9	123.8	4	55.1	5	68.5	0	0.0	5	68.0
Franklin	11	23.0	6	12.4	12	24.3	7	13.9	1	1.9	6	11.0
Garfield	4	175.5	1	41.9	5	208.6	1	41.7	0	0.0	2	83.0
Grant	10	13.8	11	15.0	8	10.7	5	6.6	11	14.4	10	13.0
Grays Harbor	19	28.1	33	49.0	45	67.0	48	70.1	52	76.0	54	78.0
Island	8	11.5	7	9.9	16	22.4	18	24.9	18	24.6	19	26.0
Jefferson	8	31.4	17	66.2	9	34.7	2	7.7	10	37.6	8	30.0
King	357	21.0	373	21.7	342	19.7	295	16.8	298	16.8	264	15.0
Kitsap	51	22.2	43	18.7	12	5.2	23	9.9	35	14.9	30	13.0
Kittitas	24	74.3	21	60.8	15	45.0	15	44.1	9	25.9	9	26.0
Klickitat	20	108.4	12	63.9	6	31.3	7	36.3	1	5.2	2	10.0
Lewis	31	45.6	17	24.8	32	46.6	25	36.0	32	45.6	30	43.0
Lincoln	14	138.9	4	39.4	5	49.1	5	49.0	1	9.8	0	0.0
Mason	8	16.7	11	22.7	15	30.4	3	6.0	14	28.1	21	42.0
Okanogan	26	65.9	39	98.9	28	70.8	14	35.3	18	45.2	18	45.0
Pacific	17	81.2	9	42.9	6	28.6	13	61.9	5	23.8	7	33.0
Pend Oreille	11	92.8		0.0	1	8.5	4	33.9	6	50.8	3	25.0
Pierce	132	19.4	129	18.7	125	17.8	102	14.3	84	11.6	87	12.0
San Juan	4	30.2	1	7.1	2	14.2	2	13.9	5	34.2	7	47.0
Skagit	51	51.1	76	74.5	74	71.9	52	50.0	37	35.2	33	31.0
Skamania	1	10.5	1	10.4	3	30.4	0	0.0	2	20.2	1	10.0
Snohomish	109	18.9	96	16.2	109	18.0	159	25.7	99	15.8	94	15.0
Spokane	108	26.1	127	30.5	119	28.5	137	32.4	128	30.1	116	27.0
Stevens	13	34.1	13	33.5	38	94.8	26	64.5	23	56.9	8	20.0
Thurston	83	41.0	51	24.8	52	25.1	81	38.5	74	34.9	82	38.0
Wahkiakum	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Walla Walla	7	12.6	15	27.2	15	27.2	11	19.9	15	27.1	24	43.0
Whatcom	69	43.1	92	56.0	82	49.2	62	36.3	77	44.7	61	35.0
Whitman	7	17.0	7	17.0	2	4.9	3	7.4	2	4.9	3	7.0
Yakima	183	82.1	223	99.7	186	83.6	157	69.9	128	56.9	76	34.0
Total	1,560	27.1	1,649	28.3	1,580	26.8	1,481	24.8	1,394.0	23.1	1,276	20.9

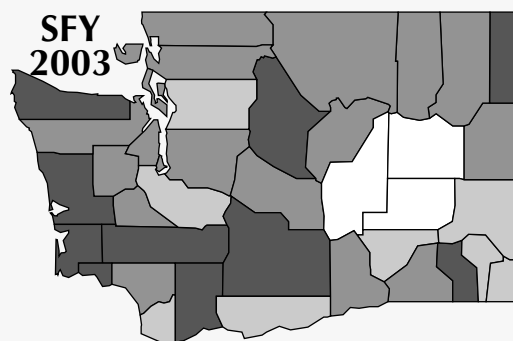
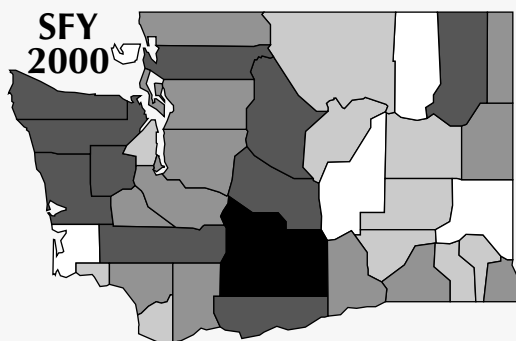
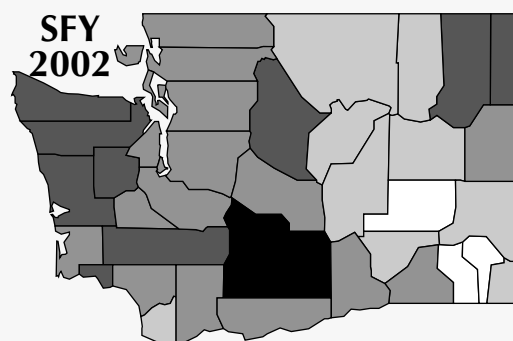
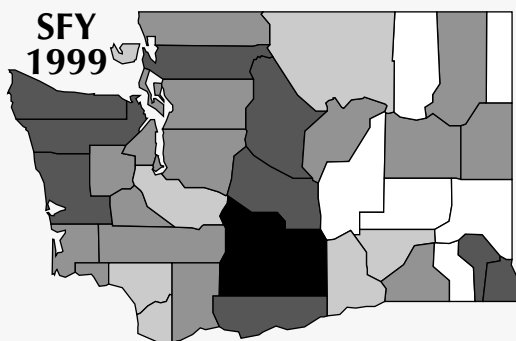
*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

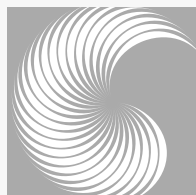
Washington State Youth Treatment Admissions for Marijuana Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service



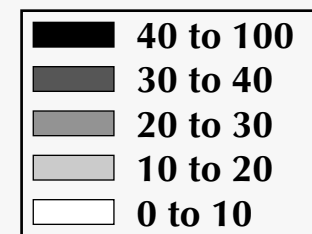
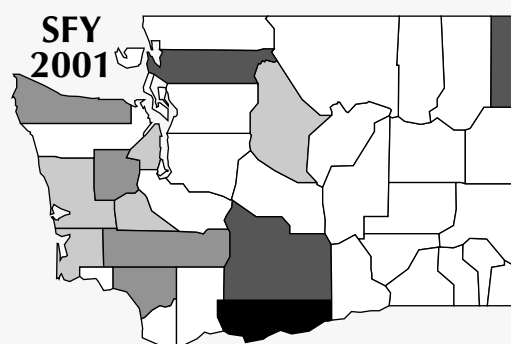
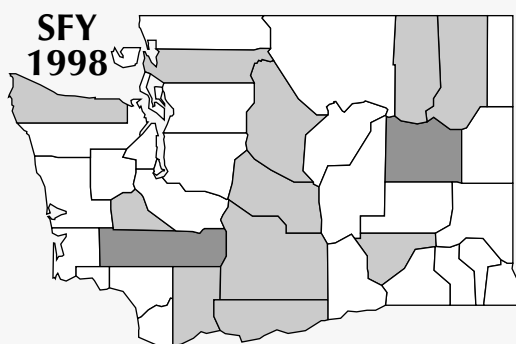


Washington State Youth Treatment Admissions * Primary Drug = Marijuana

County Name	SFY 1998		SFY 1999		SFY 2000		SFY 2001		SFY 2002		SFY 2003	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	2	12.4	2	12.4	7	42.6	4	24.1	0	0	2	12.0
Asotin	14	67.4	21	101.9	18	87.6	6	29	10	48.3	6	29.1
Benton	85	61.6	50	35.6	79	55.4	83	57.3	96	65	91	60.0
Chelan	35	52.7	68	101.6	72	108.1	70	104.3	76	112.4	70	103.1
Clallam	41	64.6	81	125.8	112	173.6	85	131.2	75	115.6	85	130.2
Clark	132	40.3	162	48	157	45.5	193	54.7	139	38.2	166	44.6
Columbia	5	111.5	1	23.4	2	49.2	1	24.4	1	24.4	5	122.0
Cowlitz	41	44.8	38	41	80	86.1	85	90.5	65	68.9	91	95.9
Douglas	12	37.4	21	64.6	11	33.7	30	91.5	9	27.2	28	83.3
Ferry	7	99.4	1	13.8	1	13.8	3	41.1	2	27.4	6	82.2
Franklin	17	35.6	15	31.1	20	40.5	11	21.8	25	48.7	25	46.6
Garfield	2	87.8	3	125.6	1	41.7	1	41.7	0	0	1	41.7
Grant	16	22.1	14	19	15	20.1	18	23.7	28	36.6	19	24.6
Grays Harbor	54	79.9	129	191.5	97	144.4	144	210.2	108	157.9	104	151.2
Island	52	74.7	44	62.4	45	62.9	31	42.8	47	64.3	47	63.5
Jefferson	35	137.5	37	144.2	39	150.3	28	107.3	35	131.6	20	74.9
King	972	57.1	1012	58.8	1200	69.1	1016	57.8	978	55.1	922	51.8
Kitsap	157	68.3	120	52.3	83	35.8	118	50.6	153	65.2	89	37.6
Kittitas	29	89.8	36	104.2	42	125.9	19	55.9	30	86.2	24	68.2
Klickitat	38	205.9	22	117.1	25	130.5	16	82.9	12	62.2	5	25.9
Lewis	68	100.1	50	72.9	90	131.2	102	146.8	108	153.8	101	143.5
Lincoln	9	89.3	8	78.9	5	49.1	2	19.6	5	49	2	19.8
Mason	31	64.7	32	66	51	103.2	44	88.7	62	124.5	46	91.6
Okanogan	8	20.3	15	38	19	48	28	70.5	19	47.7	21	53.0
Pacific	20	95.5	16	76.3	4	19.1	19	90.5	17	81	40	191.4
Pend Oreille	5	42.2	0	0	7	59.7	7	59.3	17	144.1	12	101.7
Pierce	420	61.7	306	44.2	376	53.7	310	43.5	374	51.6	360	49.1
San Juan	10	75.5	6	42.8	3	21.3	9	62.5	12	82.2	12	81.1
Skagit	113	113.2	120	117.6	153	148.6	138	132.6	71	67.6	82	76.9
Skamania	4	41.8	6	62.6	7	70.9	6	60.6	9	90.9	12	121.2
Snohomish	293	50.9	300	50.7	388	64	349	56.4	338	53.8	310	48.6
Spokane	295	71.3	365	87.6	364	87.1	382	90.4	401	94.2	400	93.3
Stevens	22	57.7	35	90.3	45	112.3	60	148.9	47	116.3	31	76.4
Thurston	181	89.4	181	88.1	160	77.2	193	91.8	147	69.2	186	86.6
Wahkiakum	2	51.5	2	51.6	1	26.2	0	0	4	105.3	4	105.3
Walla Walla	29	52.2	32	58.1	35	63.4	42	76.1	35	63.2	47	84.2
Whatcom	125	78	132	80.3	155	92.9	137	80.3	168	97.6	152	87.1
Whitman	11	26.8	9	21.8	3	7.4	13	32.3	16	39.4	12	29.3
Yakima	447	200.6	568	254	526	236.3	480	213.8	473	210.2	417	184.5
Total	3,839	66.8	4,060	69.6	4,498	76.3	4,283	71.7	4,212	69.7	4,053	66.5

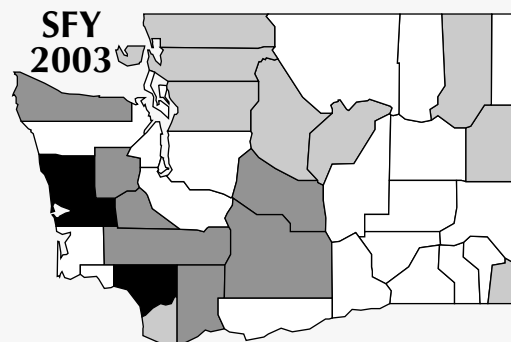
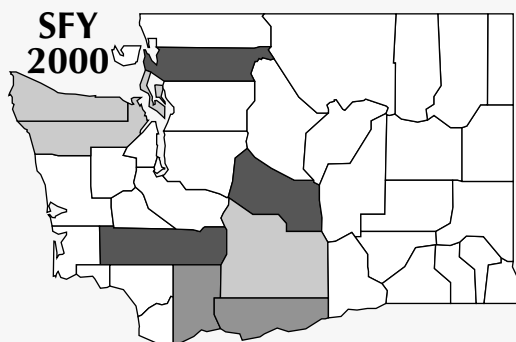
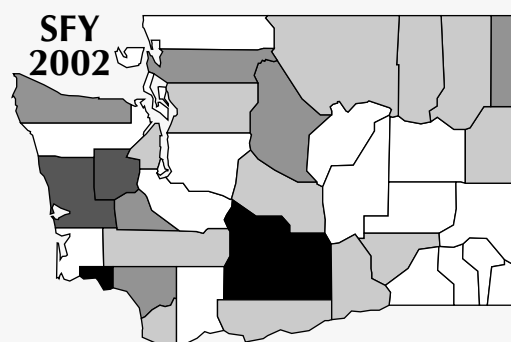
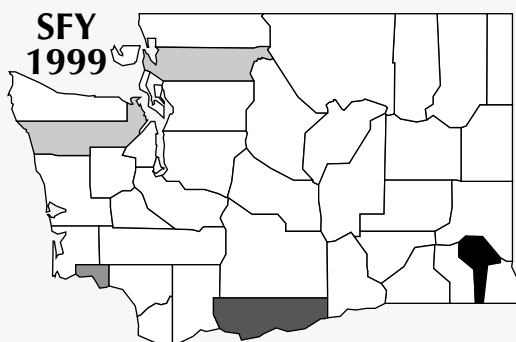
*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

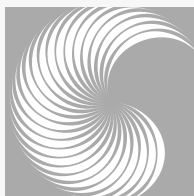
Washington State Youth Treatment Admissions for Methamphetamine Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service



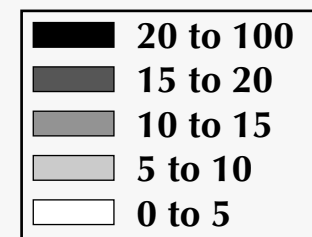
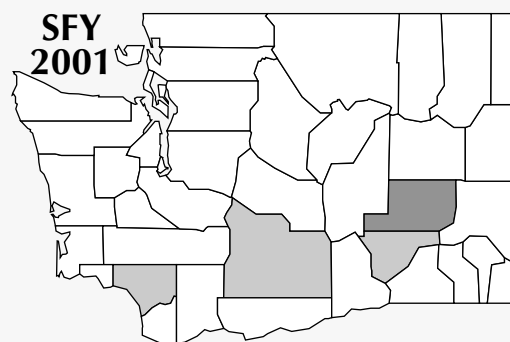
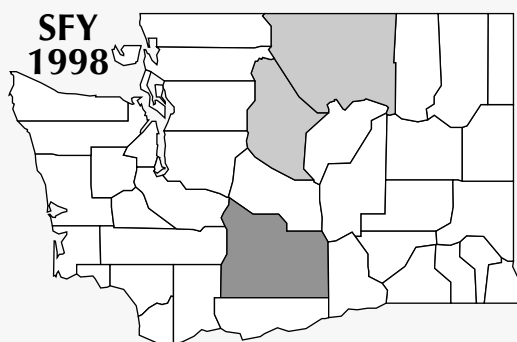


Washington State Youth Treatment Admissions* Primary Drug = Methamphetamine

County Name	SFY 1998		SFY 1999		SFY 2000		SFY 2001		SFY 2002		SFY 2003	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	0	0	0	0	0	0	0	0	0	0	0	0
Asotin	0	0	1	4.9	1	4.9	0	0	2	9.7	2	10.0
Benton	10	7.3	4	2.8	3	2.1	13	9	17	11.5	11	7.0
Chelan	12	18.1	4	6	4	6	15	22.4	14	20.7	11	16.0
Clallam	11	17.3	6	9.3	10	15.5	17	26.2	15	23.1	21	32.0
Clark	26	7.9	24	7.1	33	9.6	31	8.8	48	13.2	37	10.0
Columbia	0	0	0	0	0	0	0	0	0	0	0	0
Cowlitz	8	8.7	5	5.4	9	9.7	26	27.7	27	28.6	53	56.0
Douglas	3	9.4	1	3.1	0	0	3	9.1	2	6	4	12.0
Ferry	1	14.2	0	0	0	0	0	0	1	13.7	0	0
Franklin	5	10.5	0	0	2	4.1	3	6	6	11.7	2	4.0
Garfield	0	0	1	41.9	0	0	0	0	0	0	0	0
Grant	4	5.5	0	0	0	0	1	1.3	5	6.5	0	0
Grays Harbor	7	10.4	5	7.4	6	8.9	12	17.5	23	33.6	29	42.0
Island	7	10.1	8	11.3	11	15.4	3	4.1	4	5.5	3	4.0
Jefferson	1	3.9	3	11.7	5	19.3	2	7.7	4	15	2	7.0
King	41	2.4	39	2.3	68	3.9	70	4	75	4.2	82	5.0
Kitsap	17	7.4	8	3.5	26	11.2	31	13.3	31	13.2	15	6.0
Kittitas	6	18.6	4	11.6	11	33	5	14.7	5	14.4	7	20.0
Klickitat	5	27.1	0	0	5	26.1	11	57	2	10.4	0	0
Lewis	26	38.3	8	11.7	26	37.9	21	30.2	14	19.9	18	26.0
Lincoln	4	39.7	0	0	1	9.8	0	0	0	0	1	10.0
Mason	6	12.5	2	4.1	7	14.2	14	28.2	15	30.1	11	22.0
Okanogan	2	5.1	1	2.5	0	0	2	5	4	10.1	2	5.0
Pacific	0	0	1	4.8	3	14.3	3	14.3	2	9.5	1	5.0
Pend Oreille	1	8.4	0	0	1	8.5	4	33.9	3	25.4	0	0
Pierce	45	6.6	40	5.8	54	7.7	64	9	40	5.5	65	9.0
San Juan	0	0	0	0	0	0	3	20.8	0	0	2	14.0
Skagit	24	24	19	18.6	34	33	42	40.3	23	21.9	13	12.0
Skamania	3	31.4	1	10.4	1	10.1	0	0	0	0	3	30.0
Snohomish	36	6.2	20	3.4	27	4.5	38	6.1	65	10.4	61	10.0
Spokane	38	9.2	15	3.6	40	9.6	42	9.9	51	12	57	13.0
Stevens	4	10.5	0	0	1	2.5	3	7.4	6	14.9	4	10.0
Thurston	28	13.8	17	8.3	11	5.3	40	19	45	21.2	42	20.0
Wahkiakum	0	0	1	25.8	0	0	0	0	2	52.6	0	0
Walla Walla	5	9	3	5.4	2	3.6	3	5.4	3	5.4	5	9.0
Whatcom	7	4.4	8	4.9	17	10.2	14	8.2	17	9.9	22	13.0
Whitman	0	0	1	2.4	1	2.5	1	2.5	0	0	0	0
Yakima	46	20.6	20	8.9	34	15.3	80	35.6	102	45.3	45	20.0
Total	439	7.6	270	4.6	454	7.7	617	10.3	673	11.1	631	10.3

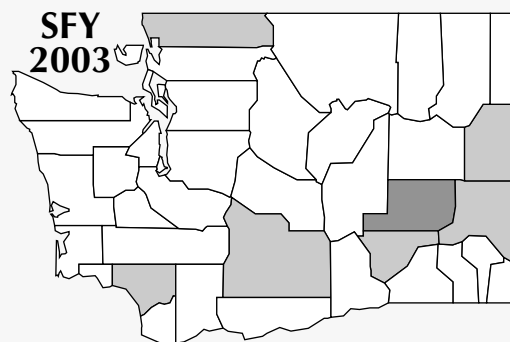
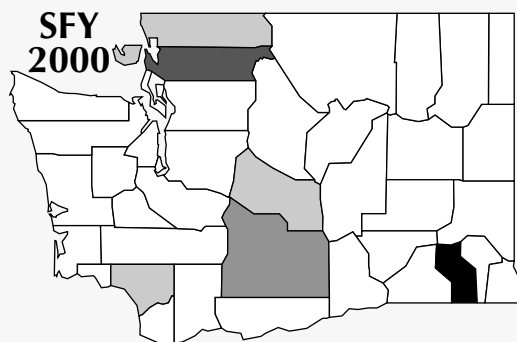
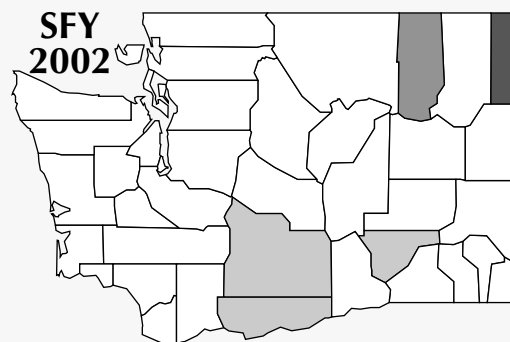
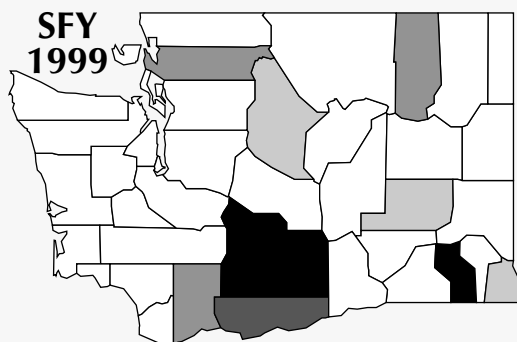
*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

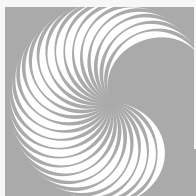
Washington State Youth Treatment Admissions for Cocaine Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service



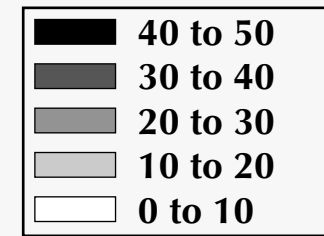
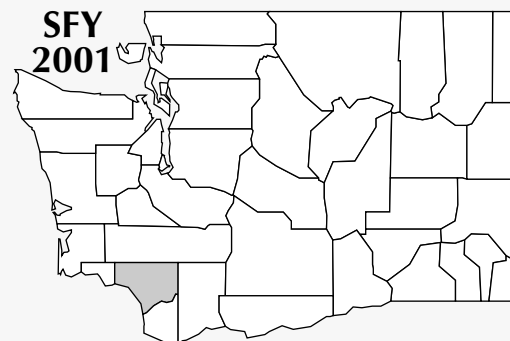
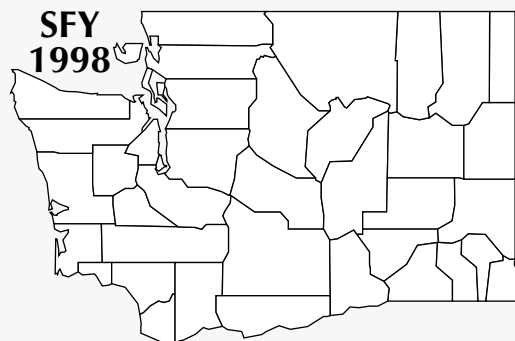
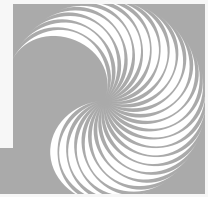


Washington State Youth Treatment Admissions* Primary Drug = Cocaine

County Name	SFY 1998		SFY 1999		SFY 2000		SFY 2001		SFY 2002		SFY 2003	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	0	0	1	6.2	0	0	2	12	0	0	2	12.0
Asotin	0	0	2	9.7	0	0	0	0	1	4.8	0	0
Benton	1	0.7	1	0.7	2	1.4	4	2.8	1	0.7	3	2.0
Chelan	5	7.5	4	6	0	0	3	4.5	2	3	2	2.9
Clallam	1	1.6	0	0	0	0	0	0	0	0	1	1.5
Clark	3	0.9	2	0.6	3	0.9	2	0.6	3	0.8	1	0.3
Columbia	0	0	1	23.4	1	24.6	0	0	0	0	0	0
Cowlitz	1	1.1	1	1.1	7	7.5	7	7.5	3	3.2	7	7.4
Douglas	0	0	0	0	0	0	1	3	0	0	0	0
Ferry	0	0	1	13.8	0	0	0	0	1	13.7	0	0
Franklin	1	2.1	1	2.1	0	0	4	7.9	5	9.7	3	5.6
Garfield	0	0	0	0	0	0	0	0	0	0	0	0
Grant	2	2.8	2	2.7	2	2.7	1	1.3	2	2.6	1	1.3
Grays Harbor	1	1.5	1	1.5	0	0	2	2.9	2	2.9	1	1.5
Island	0	0	3	4.3	0	0	0	0	2	2.7	2	2.7
Jefferson	1	3.9	0	0	0	0	1	3.8	0	0	1	3.7
King	24	1.4	46	2.7	35	2	33	1.9	13	0.7	21	1.2
Kitsap	1	0.4	4	1.7	2	0.9	0	0	1	0.4	0	0
Kittitas	0	0	1	2.9	3	9	0	0	0	0	1	2.8
Klickitat	0	0	3	16	0	0	0	0	1	5.2	0	0
Lewis	3	4.4	0	0	2	2.9	1	1.4	0	0	0	0
Lincoln	0	0	0	0	0	0	0	0	0	0	0	0
Mason	1	2.1	2	4.1	2	4	1	2	0	0	1	2.0
Okanogan	2	5.1	1	2.5	1	2.5	1	2.5	0	0	2	5.1
Pacific	0	0	1	4.8	1	4.8	0	0	0	0	0	0
Pend Oreille	0	0	0	0	0	0	0	0	2	16.9	0	0
Pierce	6	0.9	9	1.3	12	1.7	2	0.3	4	0.6	10	1.4
San Juan	0	0	0	0	1	7.1	0	0	0	0	0	0
Skagit	3	3	13	12.7	16	15.5	4	3.8	4	3.8	4	3.7
Skamania	0	0	1	10.4	0	0	0	0	0	0	0	0
Snohomish	10	1.7	20	3.4	20	3.3	5	0.8	22	3.5	11	1.7
Spokane	5	1.2	12	2.9	11	2.6	11	2.6	17	4	29	6.8
Stevens	0	0	0	0	1	2.5	0	0	1	2.5	0	0
Thurston	5	2.5	3	1.5	6	2.9	1	0.5	5	2.4	2	0.9
Wahkiakum	0	0	0	0	0	0	0	0	0	0	0	0
Walla Walla	0	0	0	0	1	1.8	0	0	1	1.8	0	0
Whatcom	6	3.7	5	3	11	6.6	7	4.1	8	4.6	10	5.7
Whitman	1	2.4	0	0	0	0	0	0	1	2.5	3	7.3
Yakima	29	13	58	25.9	30	13.5	21	9.4	21	9.3	19	8.4
Total	112	1.9	199	3.4	170	2.9	114	1.9	123	2	137	2.2

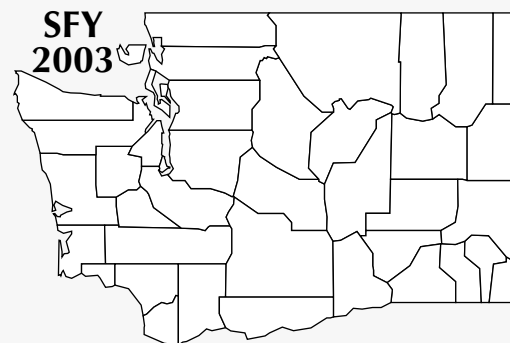
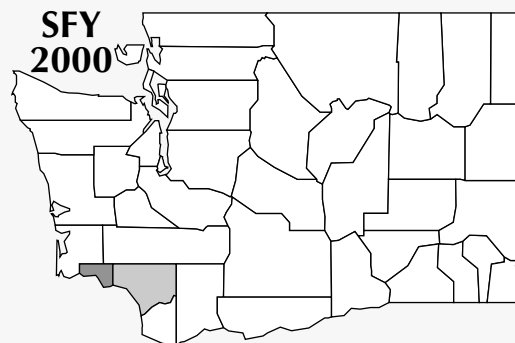
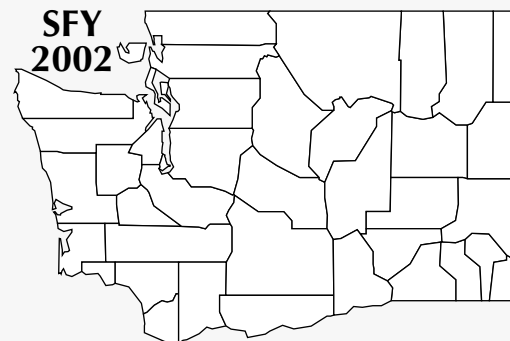
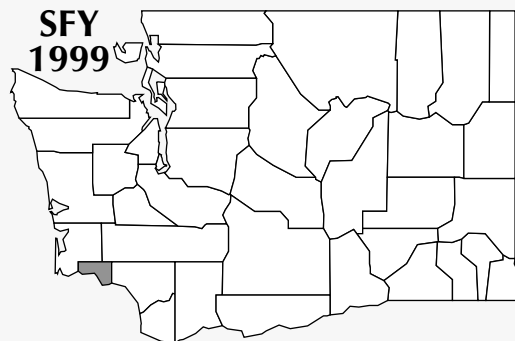
*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

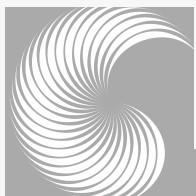
Washington State Youth Treatment Admissions for Heroin Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service



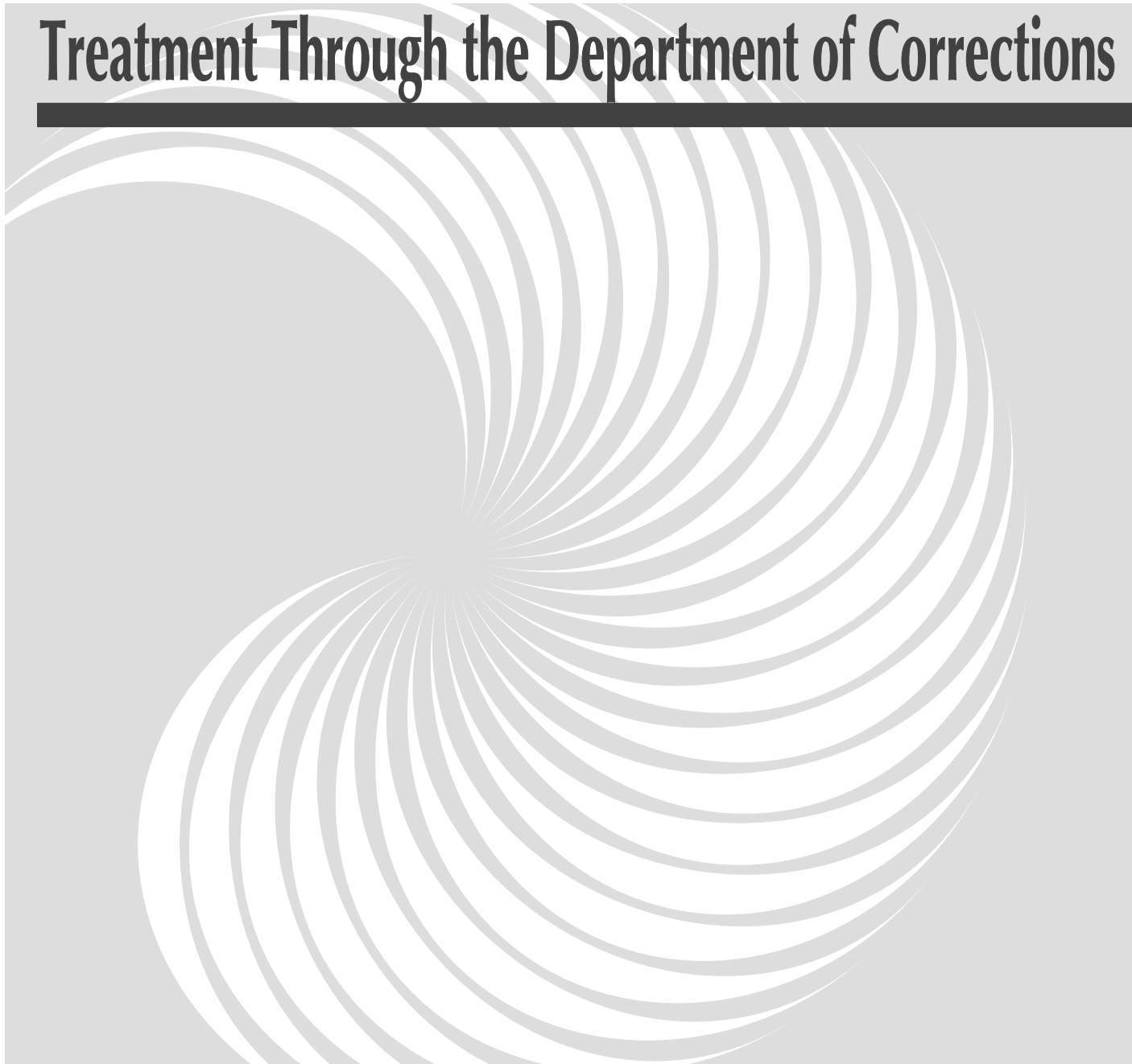


Washington State Youth Treatment Admissions* Primary Drug = Heroin

County Name	SFY 1998		SFY 1999		SFY 2000		SFY 2001		SFY 2002		SFY 2003	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	1	6.2	0	0	0	0	0	0	0	0	0	0
Asotin	0	0	0	0	0	0	0	0	1	4.8	0	0
Benton	0	0	1	0.7	0	0	1	0.7	2	1.4	1	0.7
Chelan	0	0	1	1.5	0	0	1	1.5	1	1.5	0	0
Clallam	0	0	1	1.6	0	0	0	0	0	0	0	0
Clark	3	0.9	4	1.2	0	0	1	0.3	0	0	2	0.5
Columbia	0	0	0	0	0	0	0	0	0	0	0	0
Cowlitz	4	4.4	3	3.2	12	12.9	10	10.6	3	3.2	4	4.2
Douglas	0	0	0	0	0	0	0	0	0	0	0	0
Ferry	0	0	0	0	0	0	0	0	0	0	0	0
Franklin	0	0	0	0	0	0	0	0	0	0	0	0
Garfield	0	0	0	0	0	0	0	0	0	0	0	0
Grant	0	0	0	0	0	0	1	1.3	0	0	0	0
Grays Harbor	0	0	1	1.5	0	0	0	0	0	0	0	0
Island	0	0	0	0	0	0	0	0	0	0	0	0
Jefferson	0	0	0	0	0	0	0	0	0	0	0	0
King	23	1.4	21	1.2	14	0.8	15	0.9	6	0.3	8	0.4
Kitsap	0	0	1	0.4	3	1.3	0	0	4	1.7	0	0
Kittitas	0	0	0	0	0	0	0	0	0	0	0	0
Klickitat	1	5.4	0	0	1	5.2	0	0	0	0	0	0
Lewis	1	1.5	0	0	3	4.4	1	1.4	1	1.4	1	1.4
Lincoln	1	9.9	0	0	0	0	0	0	0	0	0	0
Mason	0	0	0	0	0	0	0	0	0	0	0	0
Okanogan	0	0	0	0	0	0	0	0	0	0	0	0
Pacific	0	0	0	0	0	0	0	0	0	0	1	4.8
Pend Oreille	0	0	0	0	0	0	0	0	0	0	0	0
Pierce	4	0.6	0	0	2	0.3	1	0.1	4	0.6	3	0.4
San Juan	1	7.6	0	0	0	0	0	0	0	0	1	6.8
Skagit	6	6	8	7.8	4	3.9	1	1	2	1.9	1	0.9
Skamania	0	0	0	0	0	0	0	0	0	0	0	0
Snohomish	6	1	3	0.5	4	0.7	4	0.6	0	0	3	0.5
Spokane	1	0.2	3	0.7	0	0	1	0.2	4	0.9	2	0.5
Stevens	0	0	0	0	0	0	0	0	1	2.5	3	7.4
Thurston	7	3.5	7	3.4	6	2.9	2	1	2	0.9	2	0.9
Wahkiakum	0	0	1	25.8	1	26.2	0	0	0	0	0	0
Walla Walla	0	0	0	0	1	1.8	0	0	0	0	0	0
Whatcom	1	0.6	3	1.8	4	2.4	5	2.9	3	1.7	3	1.7
Whitman	0	0	0	0	0	0	0	0	0	0	0	0
Yakima	0	0	6	2.7	15	6.7	15	6.7	7	3.1	1	0.4
Total	60	1	64	1.1	70	1.2	59	1	41	0.7	36	0.6

*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Treatment Through the Department of Corrections





The Washington State Department of Corrections Responds to the Need for Chemical Dependency Treatment.

Over the past decade, the need for quality chemical dependency treatment among inmates in the custody of the Washington State Department of Corrections (DOC) has become increasingly apparent. More than one in five inmates in DOC custody – in prisons, pre-release facilities, and work release – were convicted of drug offenses, making drug crimes the single largest category of offenses. Of the 8,505 inmates admitted to DOC custody and screened in SFY 2003, 4,790, representing 56%, were found to be chemically dependent.¹

Responding to this need, DOC provides a multi-phased continuum of care which includes: screening; diagnostic assessment; intensive primary treatment; coordinated transition and case management; outpatient treatment; and referral to community-based treatment. All 33 DOC treatment sites are certified by the Division of Alcohol and Substance Abuse, and employ offender-specific, research-based best practices. The goal of these programs is to reduce reoffense, enhance the safety of communities, and prepare offenders for more productive lives once they are released.

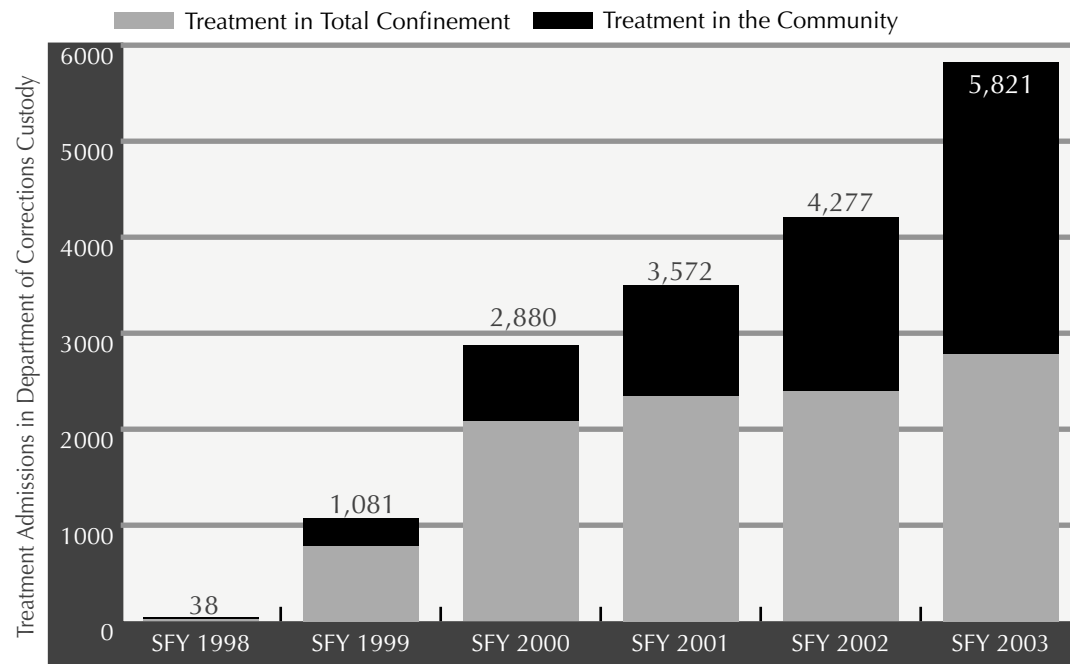
DOC provides two primary treatment modalities:

- **Modified Residential Therapeutic Community (TC)** – TC is a progressive, phased program of care, 9-12 months in length. Through modified TC, patients are provided a separate living area and a highly structured treatment environment, including traditional chemical dependency treatment coupled with emphasis upon “right living” and personal accountability. Services are delivered by a multi-disciplinary team. Development and demonstration of specific behaviors are required prior to transition to further program phases.
- **Intensive Outpatient (IOP)** – Within DOC, IOP is a high structured intervention delivered in total and partial confinement, as well as in the community. IOP is offered in varying lengths-of-stay in order to conform to the sentence structure and meet the needs of offenders in different institutions and in the community.

Following completion of a primary level of treatment, offenders are admitted to outpatient treatment. Based on the offender's clinical progress, outpatient treatment continues as needs, with a minimum of three months occurring upon release from total confinement. In geographic areas, where DOC does not provide treatment, offenders may be referred to other contracted chemical dependency providers for appropriate services.

¹ Washington State Department of Corrections, May, 2004.

Washington State Has Made a Major Commitment to Providing Chemical Dependency Treatment to Offenders in Total Confinement and Community Custody.



Source: Washington State Department of Corrections, May 2004.

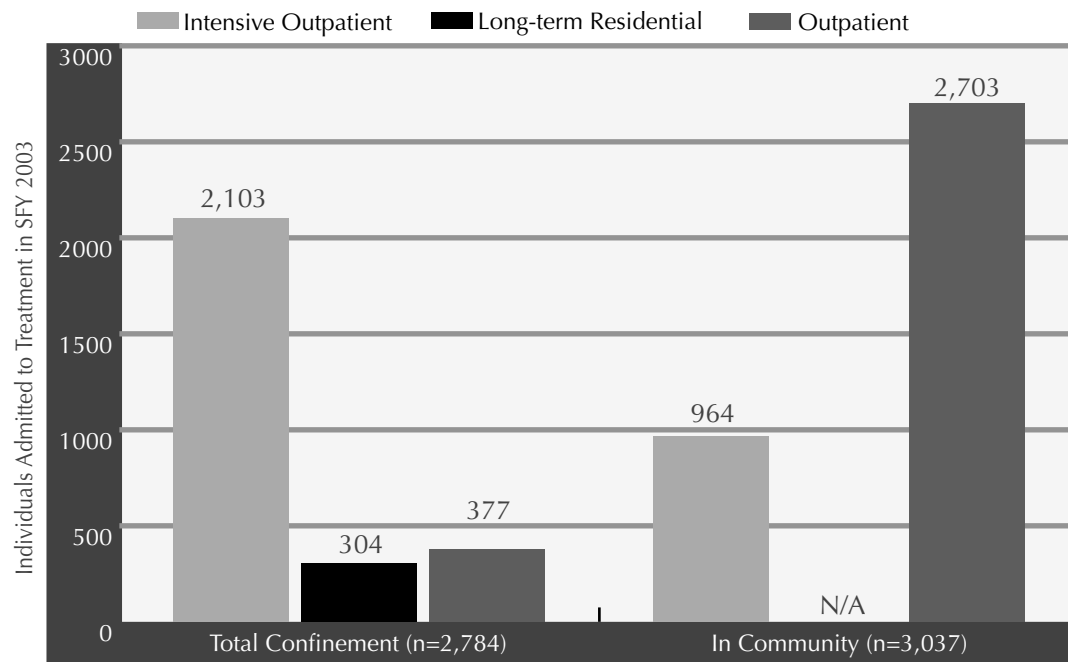
This graph indicates the depth of commitment Washington State has made in recent years toward the provision of alcohol and drug treatment services to offenders in the state correctional system. Especially noteworthy is the expansion of services to offenders in community custody. Admissions to treatment in the community now represent 52% of total admissions.

Consistent with best practices, offenders are admitted to treatment as close to release from total confinement as possible. Based on an offender's clinical progress while in confinement, outpatient treatment may continue as needed, with a minimum of three months of treatment occurring after release. Methamphetamine is the drug most commonly reported in assessments of offenders, and has more than tripled in the past five years. The treatment completion rate among offenders in Department of Corrections custody in SFY 2003 was 72%.¹



The Majority of Individuals Admitted to Chemical Dependency Treatment in the State Correctional System Receive Intensive Outpatient Treatment.

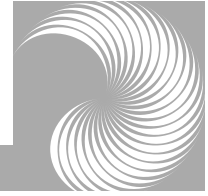
Offenders in Department of Corrections Custody Admitted to Treatment in SFY 2002



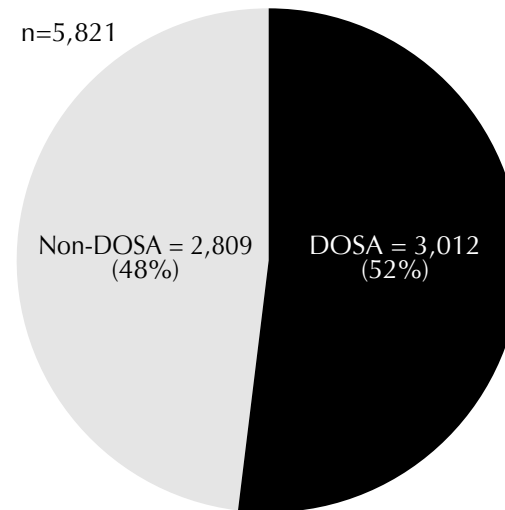
Source: Washington State Department of Corrections, May 2004.

The Washington State Department of Corrections offers three levels of chemical dependency treatment to offenders in custody who are assessed as in need. Long-term residential treatment is delivered in modified therapeutic communities, providing a highly structured living and treatment environment. Intensive outpatient treatment is provided both in correctional facilities and in communities in the form of highly structured interventions. Outpatient treatment, both in correctional facilities and in the community, follows completion of other primary levels of treatment. A minimum of three months of outpatient treatment is provided in the community, once an individual leaves total confinement.

The Majority of Individuals Receiving Chemical Dependency Treatment in the State Correctional System are Sentenced Under the Drug Offender Sentencing Alternative.



Offenders in Department of Corrections Custody Admitted to Treatment in SFY 2002



Source: Washington State Department of Corrections, May 2004.

The Drug Offender Sentencing Alternative (DOSA) provides judges with the option of ensuring those offenders who: A) pose a moderate to high risk of reoffense; B) pose a risk to public safety; and C) have had their lives disrupted due to substance abuse problems may receive chemical dependency treatment through the Department of Corrections. To qualify, offenders must have no current or prior sex or violent offenses and must not have used a deadly weapon in the commission of the offense. Additionally, if the offense was a violation of the Uniform Controlled Substance Act, the offense must have involved only a small quantity of illicit drugs.

Under DOSA, the offender serves one half of the mid-point of the standard sentencing range for the offense in total confinement, with the remainder of the term to be served in community custody. During incarceration, offenders undergo a comprehensive substance abuse assessment and receive appropriate treatment services. Services continue when the offender is released into community custody. Failure to meet conditions of the sentence – which can include drug testing and monitoring, and education or employment training – can result in imposition of the balance of the original sentence.

Outcomes: The Benefits of Prevention & Treatment

**TREATMENT
OUTCOMES
FOR:**

Adolescents

Pregnant Women

ADATSA Patients

Supplemental
Security Income
Recipients

Mentally Ill
Chemically
Abusing Patients

Individuals
Addicted to
Methamphetamine

Low-Income
Patients

Patients Receiving
Opiate Substitution
Treatment

Patient
Satisfaction



The Work of the DASA Research and Evaluation Section

The Division of Alcohol and Substance Abuse's (DASA's) Research and Evaluation Section was created to respond to the need to demonstrate the effectiveness of substance abuse prevention and treatment in serving the overall mission of the Department of Social and Health Services (DSHS), "to improve the quality of life for individuals and families in need." Through research and evaluation activities, DASA is able to document the role of alcohol- and drug-related services in enhancing client self-sufficiency; protecting vulnerable adults, children, and families; and assuring public safety and helping to build strong, healthy communities. Research also aids in the development of "best practices" that can be utilized by chemical dependency treatment providers in improving the quality of care, and provides the scientific basis for the development of sound public policy.

DASA's productivity in research and evaluation is due, at least in part, to the strong partnership it has developed with the research community over the last decade. This is most evident in the 90-member Research Subcommittee of the Citizens Advisory Council on Alcoholism and Drug Addiction. Members are drawn from research institutions throughout the Northwest. DASA also coordinates a statewide "Bridging the Gaps" workgroup, which seeks to forge new partnerships among researchers, prevention and treatment providers, and policymakers.

Current Research Efforts

Some of the results of the outcomes research conducted under the auspices of DASA on the benefits of prevention and treatment are displayed on the following pages. Below is a partial list of research projects currently underway:

- Arrestee Drug Abuse Monitoring Project
- Evaluation of the Washington State Drug-Free Workplace Program
- Statewide Household Survey to Assess Need for Treatment Among Adults in Washington State
- Treatment Outcomes of Persons with Co-Occurring Mental Health and Substance Abuse Disorders
- Outcomes of Pregnant, Postpartum, and Parenting Women Who Receive Specialized Chemical Dependency Services
- Treatment Outcomes of Parenting Women Who Participate in Specialized and Non-Specialized Long-Term Care
- Analysis of Use, Cost, and Outcomes of Opiate Substitution Treatment Services in Washington and Oregon
- School Outcomes of Youth in Publicly Funded Treatment
- Cost Offsets of Treatment for Supplemental Security Income (SSI) Recipients
- Evaluation of the RUaD (Reduce Underage Drinking) Program

In addition, the Research and Evaluation Section is assisting in development of a web-based client outcome tracking system for use by providers, county coordinators, and state-level managers.

Outcomes: The Benefits of Prevention & Treatment

**TREATMENT
OUTCOMES
FOR:**

Adolescents

Pregnant Women

ADATSA Patients

**Supplemental
Security Income
Recipients**

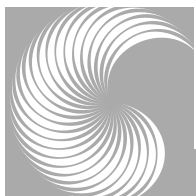
**Mentally Ill
Chemically
Abusing Patients**

**Individuals
Addicted to
Methamphetamine**

**Low-Income
Patients**

**Patients Receiving
Opiate Substitution
Treatment**

**Patient
Satisfaction**



Profile of Adolescents Served in Publicly Funded Chemical Dependency Programs in Washington State

A profile of adolescents (ages 12 through 17) admitted to publicly funded chemical dependency treatment in Washington State in SFY 2003 reveals the following characteristics at time of admission:¹

<i>Number of Individuals Admitted:</i>	5,433
<i>Median Age:</i>	15
<i>Gender:</i>	64% male; 36% female
<i>School Attendance:</i>	72% in school (at least part-time); 28% out of school
<i>Primary Drug:</i>	Marijuana - 63%; Alcohol -21%; Stimulants (including Methamphetamine) - 9%
<i>Criminal Justice Involvement:</i>	69% arrested at least once in previous year
<i>Housing Status:</i>	2% homeless*

A 1999 study of adolescents (age 20 and younger) admitted to publicly funded chemical dependency treatment revealed the following profile:

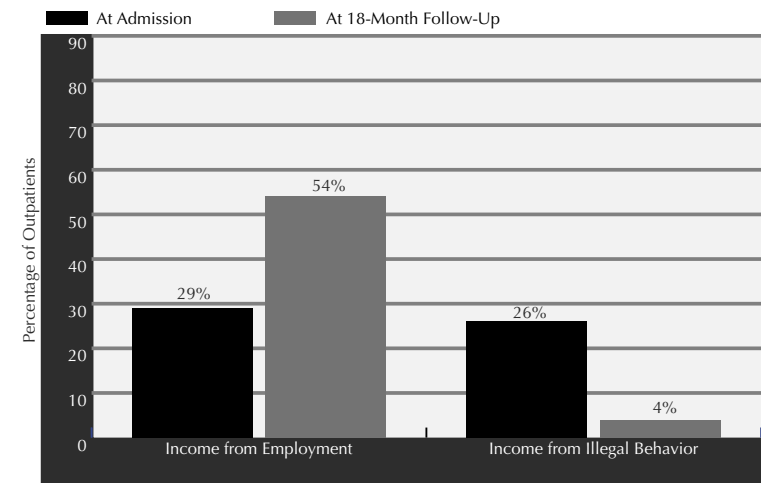
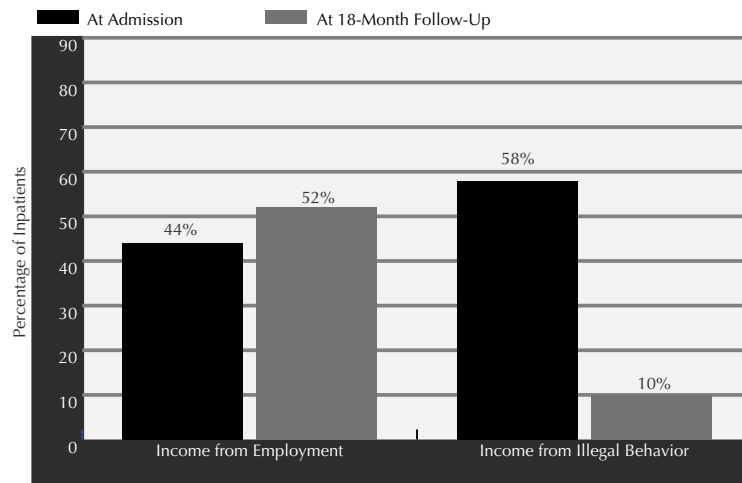
- Between 55-70% of youth admitted to residential treatment had run away from home at least once in their lives.
- Between 23-34% of youth had one or more emergency room visits in the year prior to admission.
- 90% of youth admitted to treatment began using their primary substance of abuse prior to age 16.
- Between 70-90% reported at time of admission that they currently smoke cigarettes.
- Between 23-37% of those admitted to residential treatment had been domestic violence victims.²

*Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.

¹ Research and Evaluation Section, Washington State Division of Alcohol and Substance Abuse, July 2003. Data include unduplicated admissions to treatment; detoxification, transitional housing, private-pay, and Department of Corrections patients are excluded.

² Rodriguez, F., *Profile of Youth Clients Admitted to Publicly Funded Substance Abuse Treatment Programs in Washington State, 1998*. Olympia, Washington: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999.

After Treatment, More Adolescents Reported Income Earned from Employment, and Fewer Reported Income Earned from Illegal Behavior.

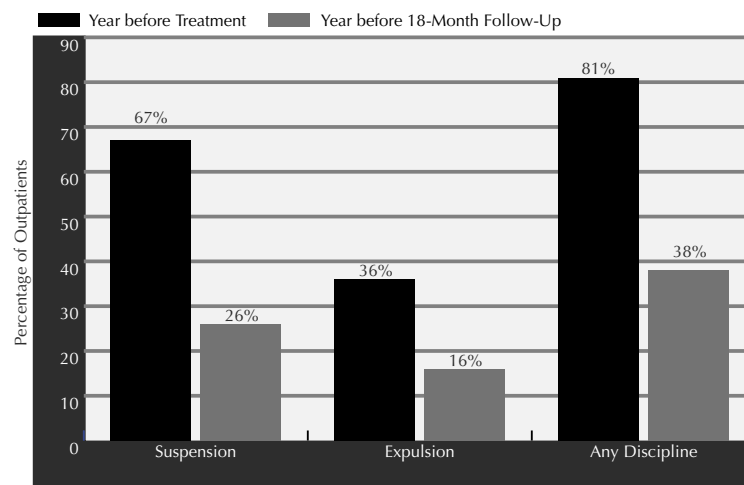
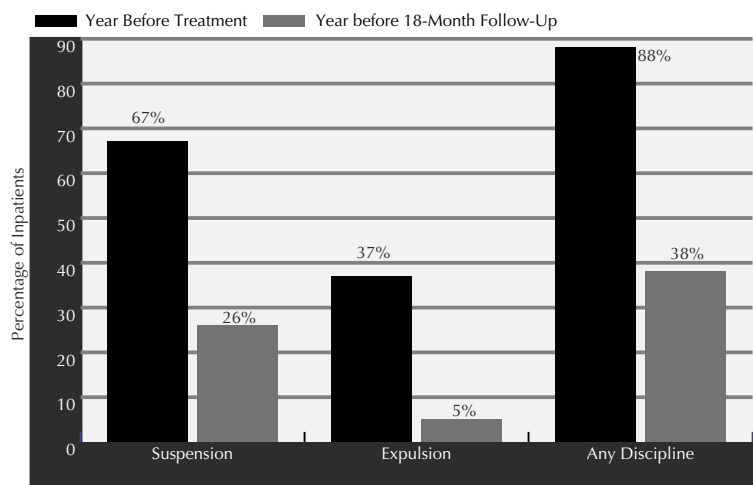


Source: New Standards, Inc. *Washington State Division of Alcohol and Substance Abuse 18-Month Adolescent Outcomes Report*. St. Paul, MN: New Standards, Inc., 1997.

At the time of admission, adolescent inpatients were more likely to report income from illegal behavior than from legitimate employment, while outpatients were almost equally as likely to report income from both sources. At the time of the 18-month follow-up, however, adolescents who had been in both inpatient and outpatient treatment were five times more likely to report income from employment rather than illegal behavior.



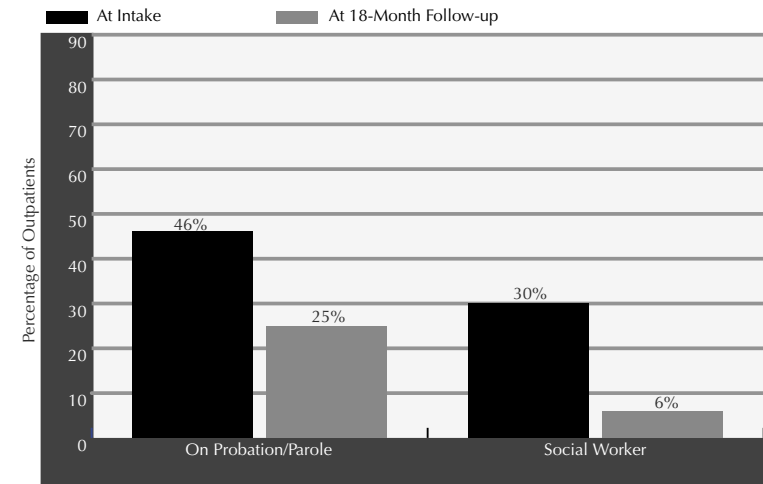
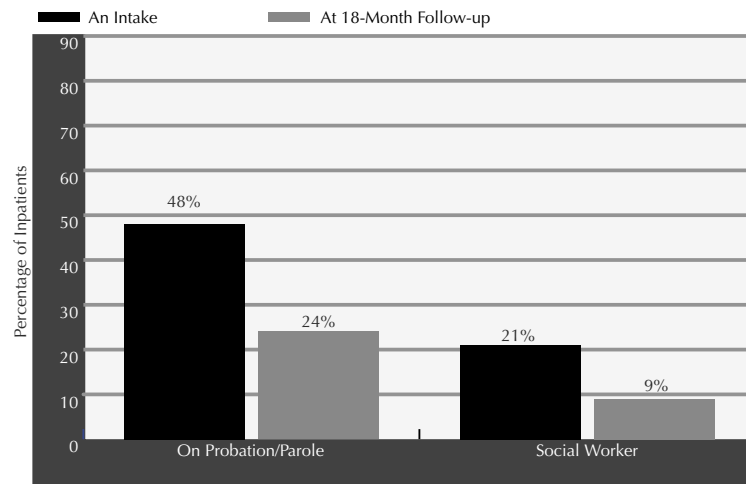
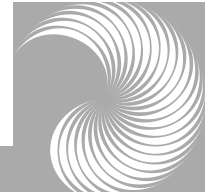
School Discipline Problems for Adolescent Patients Decreased After Treatment.



Source: New Standards, Inc. *Washington State Division of Alcohol and Substance Abuse 18-Month Adolescent Outcomes Report*. St. Paul, MN: New Standards, Inc., 1997.

Not surprisingly, adolescents with substance abuse problems tend to experience behavioral problems when attending school. After substance abuse treatment, however, the number of adolescents reporting any school discipline problems in the preceding year dropped by 50%. An especially encouraging outcome is the substantial reduction in school expulsions for youth receiving either inpatient or outpatient treatment. Additional study results also showed a corresponding improvement in school grades after treatment.

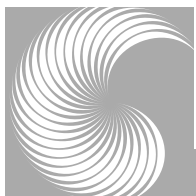
A Lower Percentage of Adolescent Patients were Under Legal Supervision 18 Months After Treatment.



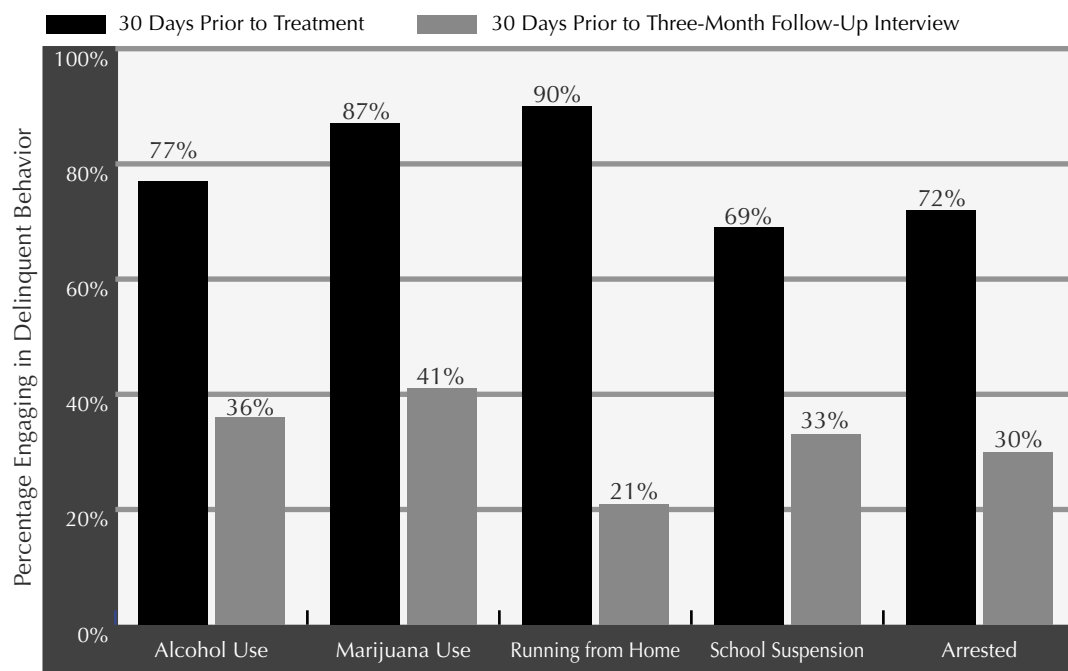
Source: New Standards, Inc. *Washington State Division of Alcohol and Substance Abuse 18-Month Adolescent Outcomes Report*. St. Paul, MN: New Standards, Inc., 1997.

A large proportion of children involved in the juvenile justice system have substance abuse problems and, similarly, a large portion of juveniles in chemical dependency treatment programs are involved in criminal activities. Therefore, it is expected that obtaining substance abuse treatment will have a positive effect on criminal behavior, as well as decreasing or ceasing substance use.

As expected, legal involvement by adolescents decreased considerably after treatment for both inpatients and outpatients. Compared to their status at intake, approximately half as many adolescents were on parole or probation at the time of follow-up. There was a similar reduction in supervision by social workers for inpatients, and only 6% of outpatients were under a social worker's supervision at the 18-month follow-up, compared to 30% at intake.



“Becca” Youth Who Complete Residential Chemical Dependency Treatment Are Much Less Likely to Use Alcohol or Marijuana, Less Likely to Run Away from Home, and Less Likely to Be Suspended from School or Arrested.

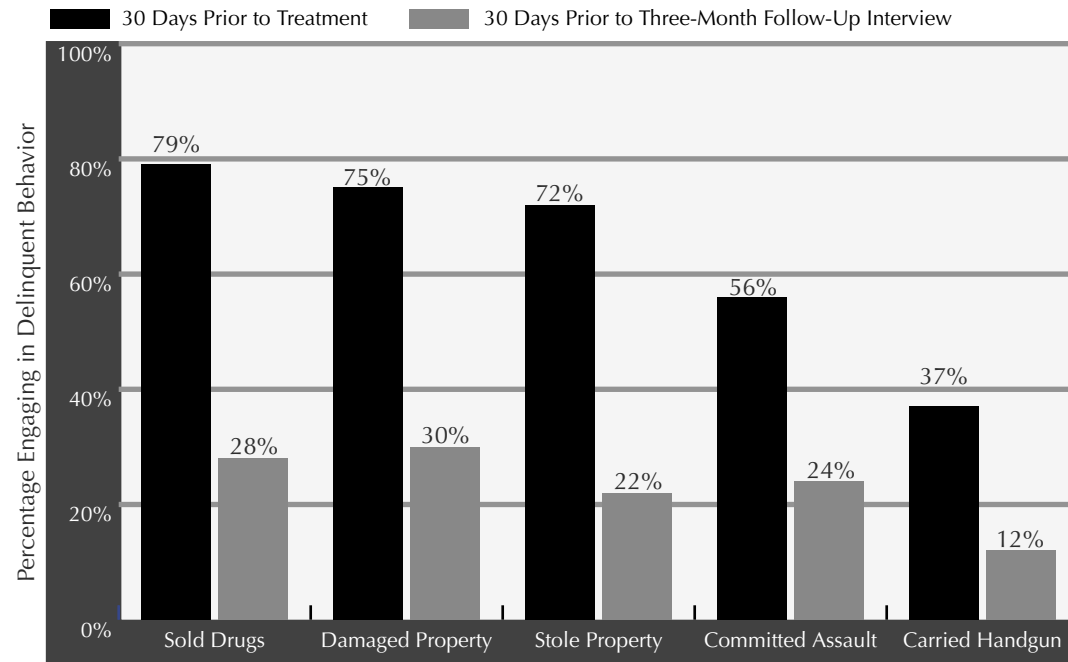
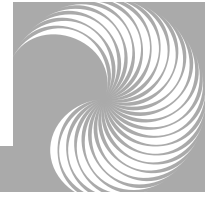


Source: Peterson, P., et al. *Treatment Outcome Evaluation: Youth Admitted to Residential Chemical Dependency Treatment Under the Provisions of the “Becca” Bill*. Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 1997.

The 1995 At-Risk/Runaway Youth Act created the “Becca” program, named after a youth who was murdered after she ran away from home. Becca youth are chemically dependent adolescents who are beyond their parent’s control and/or are chronic runaways. These youth are estimated at approximately 3-4% (1,350 to 2,250) of the 45,000 youth ages 13-19 who are in need of substance abuse treatment. Most are ages 14 to 16.

While the needs of Becca Youth are very high, this graph indicates that residential chemical dependency treatment results in significant positive changes in behavior following treatment completion.

Rates of Delinquent Behavior Among “Becca” Youth Decline Substantially Following Completion of Residential Chemical Dependency Treatment.



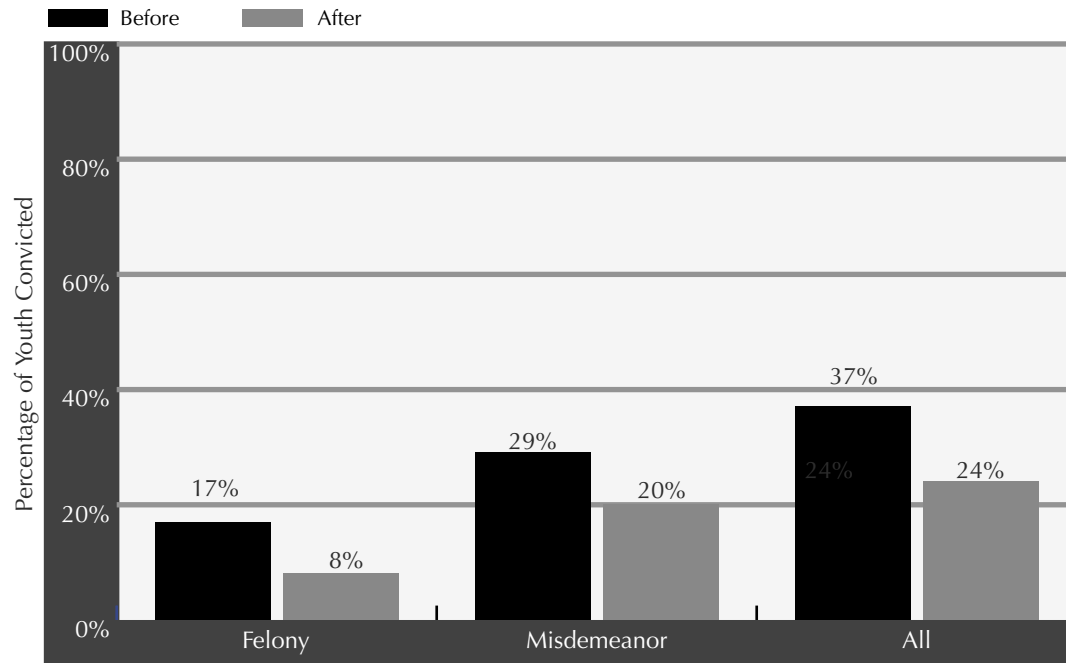
Source: Peterson, P., et al., *Treatment Outcome Evaluation: Youth Admitted to Residential Chemical Dependency Treatment Under the Provisions of the “Becca” Bill*. Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 1997.

This graph indicates that Becca youth who receive chemical dependency treatment are much less likely to engage in delinquent behavior following treatment completion. In this 1997 study conducted by the University of Washington, the percentage of Becca youth involved in selling drugs declined by 64.6%; those stealing property dropped by 60.4%; and the percentage of those who committed assault dropped by 57.1%.

The 1995 At-Risk/Runaway Youth Act created the “Becca” program, named after a youth who was murdered after she ran away from home. Becca youth are chemically dependent adolescents who are beyond their parent’s control and/or are chronic runaways. These youth are estimated at approximately 3-4% (1,350 to 2,250) of the 45,000 youth ages 13-19 who are in need of substance abuse treatment. Most are ages 14 to 16.



There are Significant Declines in Criminal Convictions Among Youth Who Receive Chemical Dependency Treatment.



Source: Luchansky, B., et al., "Treatment Readmissions and Criminal Recidivism in Youth Following Participation in Chemical Dependency Treatment." Olympia, WA: Washington State Department of Social and Health Services, 2003.

A 2003 study of almost 6,000 Washington State youth ages 14-17 found significant declines in criminal convictions following chemical dependency treatment. The rate of all convictions fell from 37% in the 18 months prior to treatment to 24% in the 18 months following treatment, representing a 35% decline. Felony convictions declined by 56%; misdemeanors fell by 30%.

However, waiting lists for publicly funded chemical dependency treatment for youth remain very long. Average wait time for youth residential treatment in April 2004 was approximately 4-6 weeks.

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Individuals
Addicted to
Methamphetamine

Low-Income
Patients

Patients Receiving
Opiate Substitution
Treatment

Patient
Satisfaction



Profile of Pregnant Women Served in Publicly Funded Chemical Dependency Treatment Programs in Washington State

A profile of pregnant women admitted to publicly funded chemical dependency treatment in Washington State in SFY 2003 reveals the following characteristics at time of admission:¹

<i>Number of Individuals Admitted:</i>	506
<i>Median Age:</i>	23
<i>Employment Status:</i>	Employed (full- or part-time) – 8%; Unemployed – 92%
<i>Primary Drug:</i>	Stimulants (including Methamphetamine) - 34%; Alcohol – 21%; Marijuana - 20%
<i>Criminal Justice Involvement:</i>	61% arrested at least once in previous year
<i>% with Children in the Home:</i>	40%
<i>Housing Status:</i>	10% homeless*

A 1999 study of pregnant, post-partum, and/or parenting women (PPWs) admitted to publicly funded chemical dependency treatment in Washington State indicated:

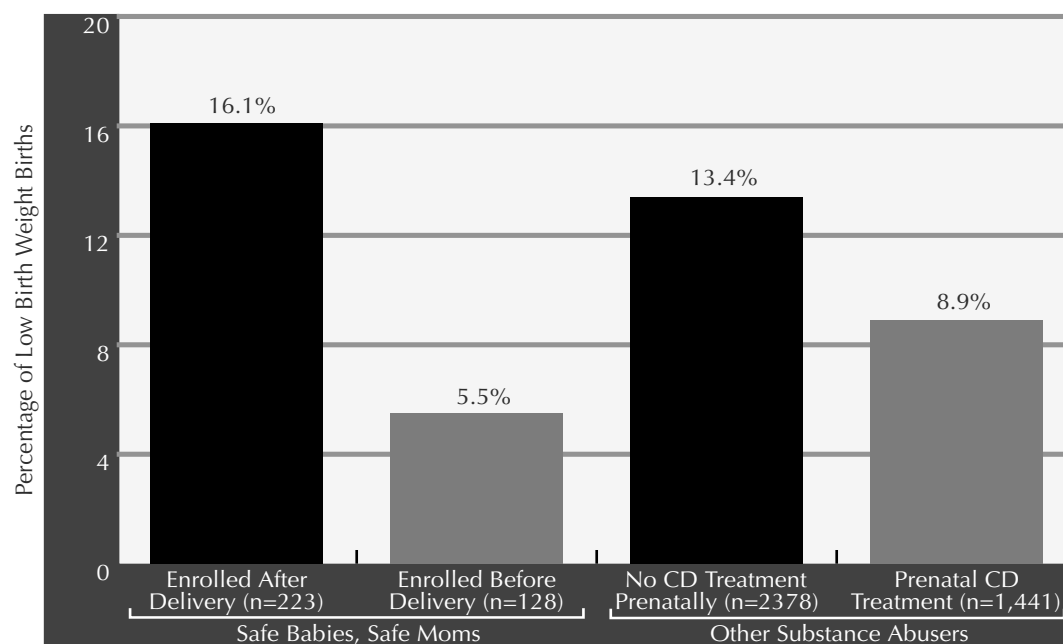
- More than 60% of PPWs admitted to treatment had been victims of domestic violence.
- Over 50% reported public assistance as their primary source of income.
- Between 38-73% had visited an emergency room one or more times in the year prior to treatment admission.
- Over one-quarter reported having received mental health treatment in the year prior to admission.
- Between 26-63% reported having used injection drugs.
- Between 77-92% reported they currently smoke cigarettes.³

* Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.

¹ Research and Evaluation Section, Washington State Division of Alcohol and Substance Abuse, July 2003. Data include unduplicated admissions to treatment; detoxification, transitional housing, private-pay, and Department of Corrections patients are excluded.

² Rodriguez, F., *Profile of Pregnant, Post-Partum, and/or Parenting Women (PPWs) Admitted to Publicly Funded Substance Abuse Treatment Programs in Washington State, 1998*. Olympia, Washington: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999.

Substance-Abusing Women Who Received Chemical Dependency Treatment were Less Likely to Have a Low Birth Weight Baby.



Source: Cawthon, L., "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

Low birth weight (LBW) – newborn infants weighing less than 5.5 pounds, or 2,500 grams—is the risk factor most closely associated with neonatal death, and is associated with a wide range of disorders, including neurodevelopmental conditions, mental retardation, vision and hearing impairments, and other developmental disabilities. Alcohol and other drug abuse is linked to LBW.¹

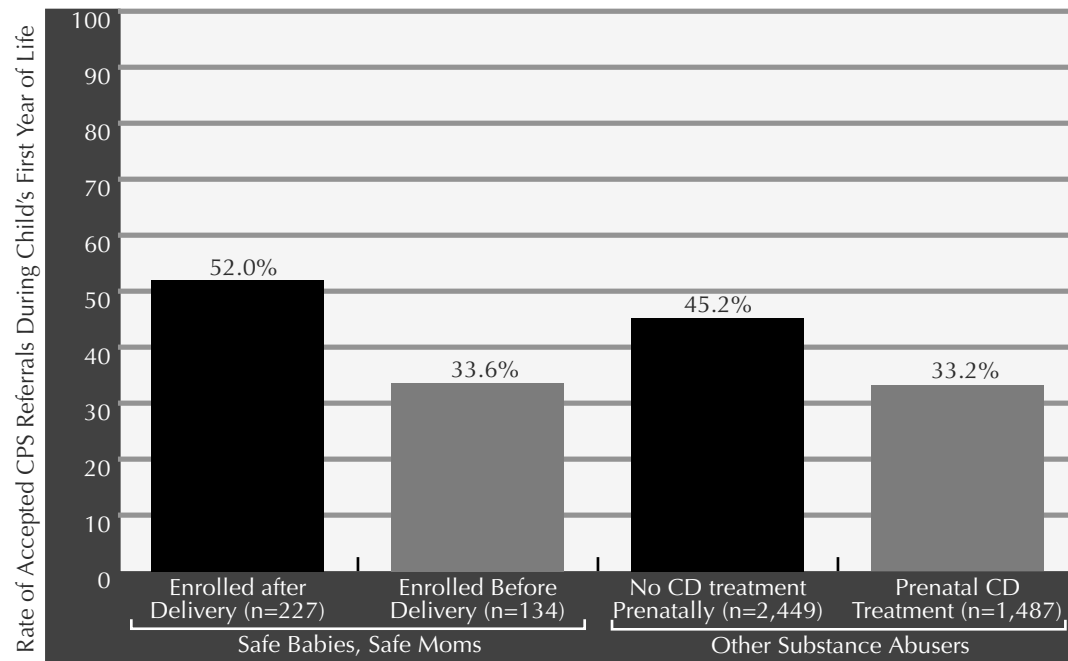
Substance-abusing pregnant mothers receiving comprehensive services, including chemical dependency treatment, prenatally, through the Safe Babies, Safe Moms program, were 66% less likely to give birth to an LBW baby, compared with substance-abusing women who enroll after delivery. Outside of the program, substance-abusing women who received chemical dependency treatment prenatally were 34% less likely to give birth to an LBW baby, compared with women who did not receive treatment.²

¹ U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 16-4, 5, 34. Washington, DC: 2000.

² Cawthon, L., "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.



Substance-Abusing Women Who Received Chemical Dependency Treatment Prenatally were Less Likely to Be Referred Later to Child Protective Services.



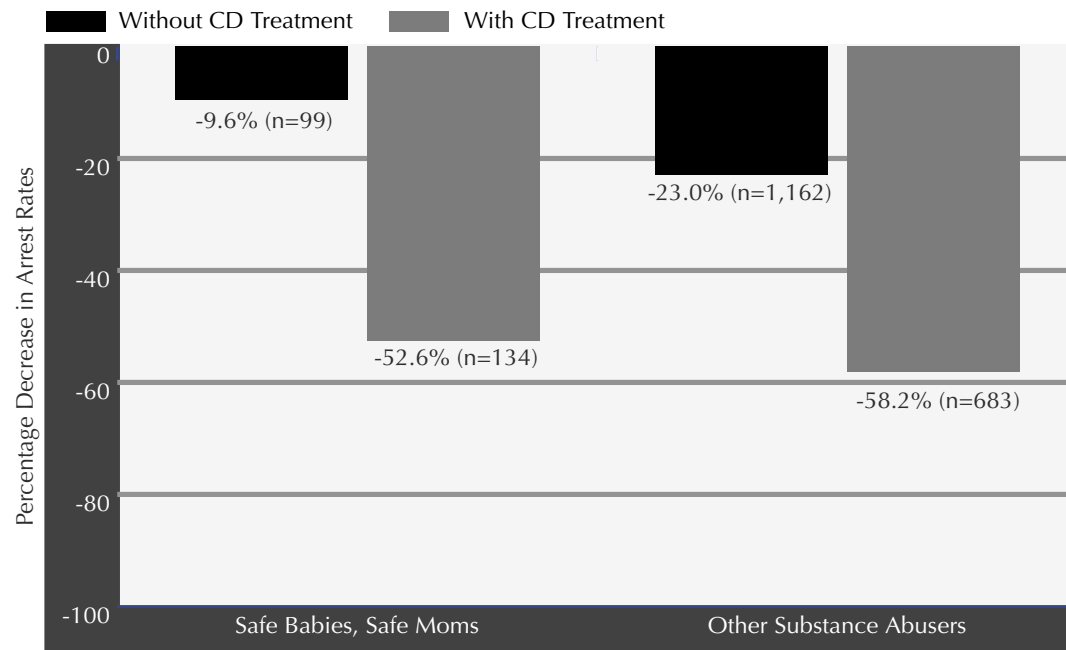
Source: Cawthon, L., "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

Child abuse and neglect is one of the most important consequences of maternal substance abuse. The rate of accepted referrals to Child Protective Services (CPS) during a child's first year of life is ten times higher (45.2%) when their substance-abusing mothers did not receive chemical dependency treatment than for infants on Medicaid whose mothers are not substance abusers (4.5%).

Substance-abusing pregnant mothers receiving comprehensive services, including chemical dependency treatment prenatally, through the Safe Babies, Safe Moms program, were 35.4% less likely to be referred to CPS during the first year of their child's life than those enrolling after their child was born. Outside of the program, substance-abusing women who received chemical dependency treatment prenatally were 26.5% less likely to be referred to CPS during the first year of their child's life than substance-abusing women who did not receive treatment.¹

¹ Cawthon, L., "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

Substance-Abusing Pregnant Women Who Received Chemical Dependency Treatment were Less Likely to Be Arrested.



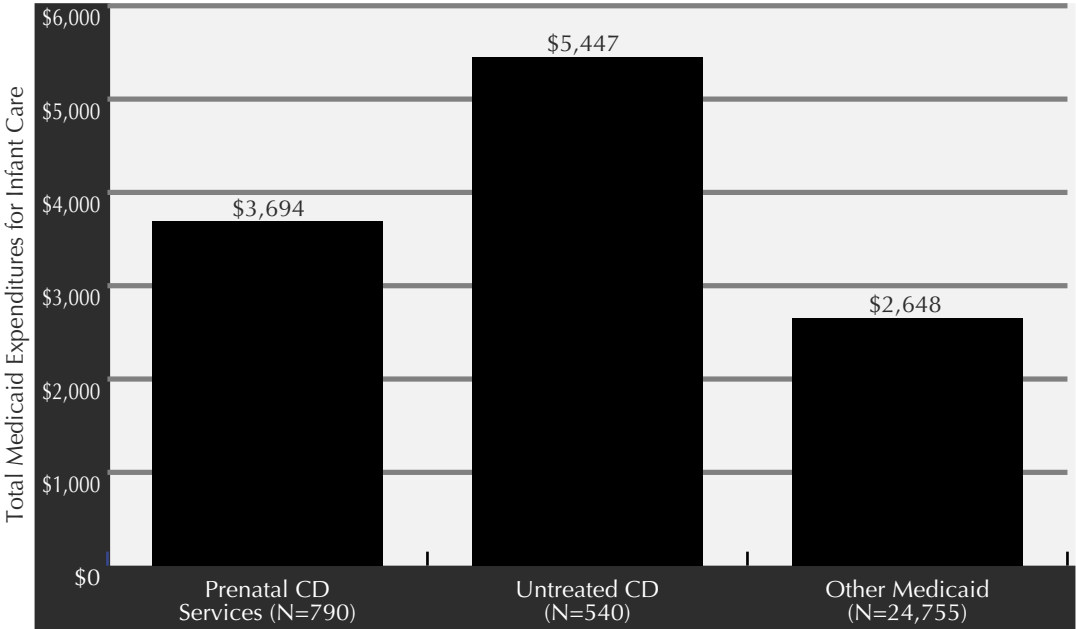
Source: Cawthon, L., "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

Criminal justice involvement is a significant issue for many pregnant, substance-abusing women. In addition to the burden of drug- and alcohol-related crime on society, crime presents serious health and developmental risks to children, both prenatally and after they are born.

Among women enrolled in the Safe Babies, Safe Moms program, those who received chemical dependency treatment had more than a five times greater reduction in arrest rates in the following two years compared with those who did not receive treatment. Outside of the program, among substance-abusing pregnant women, those who received chemical dependency treatment had more than double the reduction in arrest rates in the following two years after delivery compared with those who did not receive treatment.¹

¹ Cawthon, L., "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

Average Medicaid Costs During the First Two Years of Life were Lower for Infants Born to Women Who Received Chemical Dependency Treatment in the Prenatal Period than for Those Born to Substance-Abusing Women Who Did Not Receive Treatment.



Source: Cawthon, L., & Schrager, L. "Substance Abuse Treatment and Birth Outcomes for Pregnant and Postpartum Women in Washington State." *First Steps Database* 5(1). Washington State Department of Social and Health Services, 1995.

Low birth weight (LBW – newborn infants weighing less than 5.5 pounds, or 2,500 grams) is the single most important factor in determining infant medical care expenditures during the neonatal period. Alcohol and other drug use is associated with LBW.¹

This graph indicates that average Medicaid expenditures for care during the first two years of life for infants born to untreated substance abusers was 47.5% higher than for substance-abusing women who received chemical dependency treatment during pregnancy, and more than twice that for infants born to non-substance abusing women receiving Medicaid.

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-4, 5, 34. Washington, DC: 2000.

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Patients

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Opiate Substitution
Treatment

Patient
Satisfaction



Profile of ADATSA Patients Receiving Publicly Funded Chemical Dependency Treatment in Washington State

A profile of patients admitted to publicly funded chemical dependency treatment under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) in Washington State in SFY 2003 reveals the following characteristics at time of admission:¹

<i>Number of Individuals Admitted:</i>	7,219
<i>Median Age:</i>	35
<i>Gender:</i>	66% Male; 34% Female
<i>Employment Status:</i>	Employed (full- or part-time or temporary) – 4%; Unemployed – 96%
<i>Primary Drug:</i>	Alcohol – 44%; Stimulants (including Methamphetamine) – 23%; Marijuana - 11%; Cocaine/Crack – 12%
<i>Criminal Justice Involvement:</i>	69% arrested at least once in previous year
<i>% with Children in the Home:</i>	20%
<i>Housing Status:</i>	23% homeless*

Enacted in 1987, the ADATSA legislation created a program to treat adults addicted to alcohol or other drugs. To qualify, clients must be indigent, unemployable, and incapacitated due to their addiction. Patients may be admitted to either residential or outpatient modalities of treatment as individually required. The immediate goal of the program is abstinence, while ancillary goals include improved personal coping skills, as well as social and vocational skills. Success in moving toward these goals is expected to result moving toward the long-term objective of self-sufficiency.

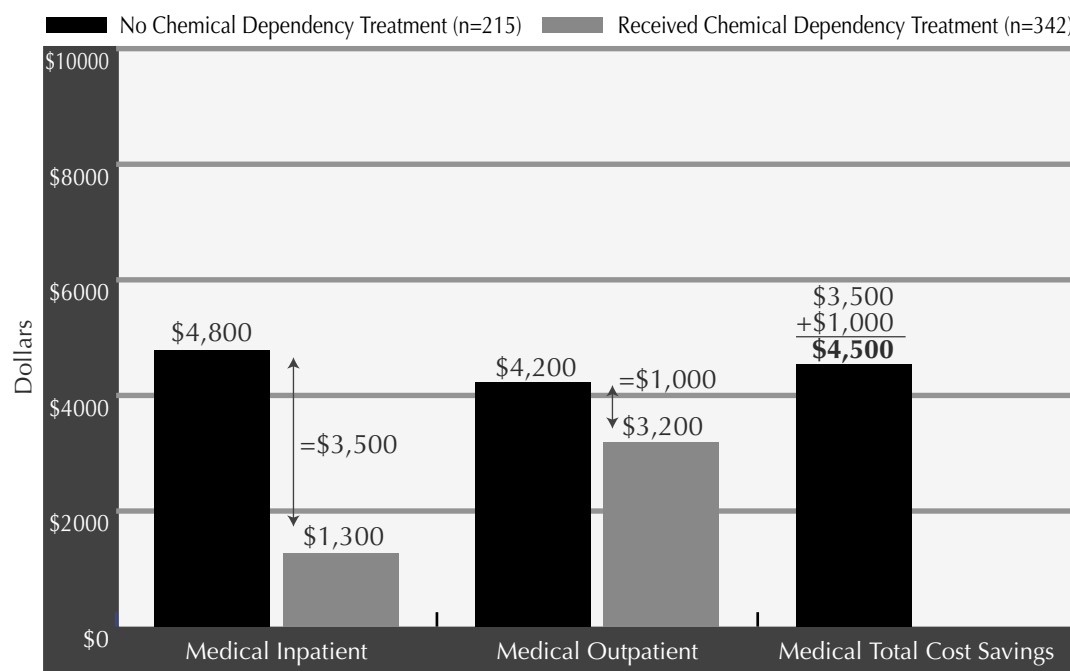
The average ADATSA patient has had a 15-year history of substance abuse, starting at age 16, with one or more prior treatment episodes. Approximately two-thirds are white, and one-third ethnic minorities. A significant proportion of patients suffer from physical, mental, or emotional problems in addition to their addiction.²

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

¹ Data include unduplicated admissions to treatment; detoxification, transitional housing, private-pay, and Department of Corrections patients are excluded.

² Van Der Hyde, V., et al., *ADATSA Follow-Up Study of Extended Outpatient Care: A Comparison of 90 Days Versus 180 Days of Outpatient Treatment for Clients of Washington State's Alcoholism and Drug Addiction Treatment and Support Act*. Olympia, WA: Washington State Department of Social and Health Services, Office of Research and Data Analysis, 1995.

Average Medical Costs for ADATSA Patients Who Received Chemical Dependency Treatment were \$4,500 Lower than Those for Untreated Patients Over a Five-Year Follow-Up Period.

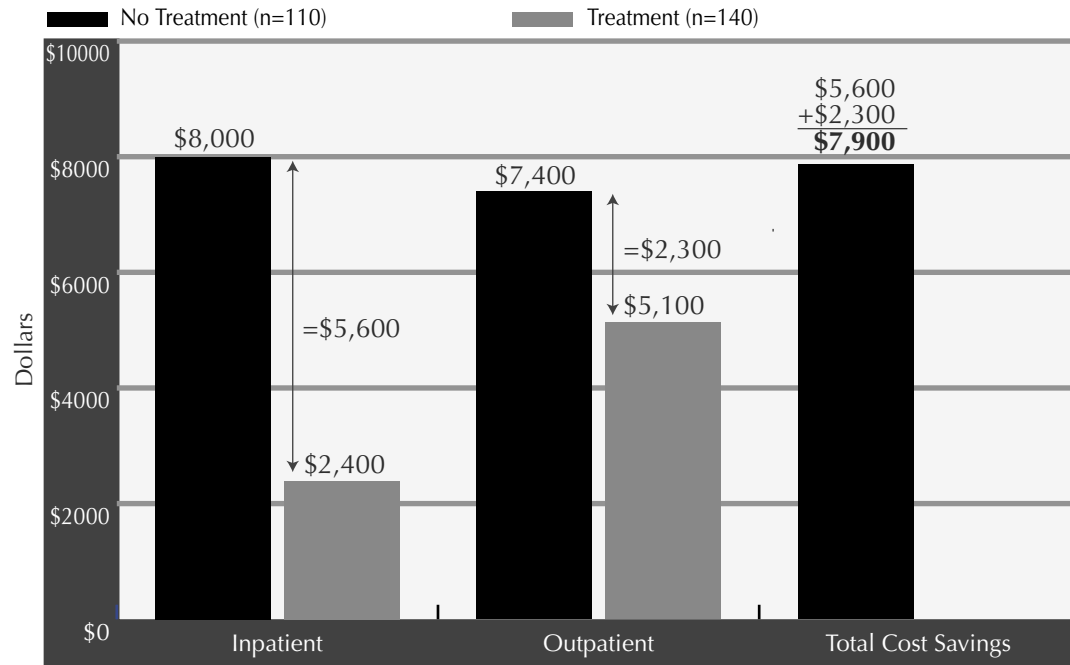


Source: Luchansky, B., & Longhi, D. *Cost Savings in Medicaid Expenses: An Outcome of Publicly Funded Chemical Dependency Treatment in Washington State: A Five-Year Cost Savings Study of Indigent Persons Served by Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, 1997.

This graph indicates that chemical dependency treatment can result in lower medical expenses. Over a five-year period, treated ADATSA patients had medical costs averaging \$4,500 less than those who did not receive treatment. Inpatient hospital expenses averaged \$3,500 less, while outpatient medical expenses averaged \$1,000 less.¹

¹ Luchansky, B., & Longhi, D., *Cost Savings in Medicaid Expenses: An Outcome of Publicly Funded Chemical Dependency Treatment in Washington State: A Five-Year Cost Savings Study of Indigent Persons Served by Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)*. Olympia, WA: Washington State Department of Social and Health Service, Research and Data, Analysis, 1997.

For ADATSA Patients with Medicaid Medical Expenses Prior to Admission, Chemical Dependency Treatment was Associated with \$7,900 in Overall Savings in Medical Expenses Over a Five-Year Follow-Up Period.

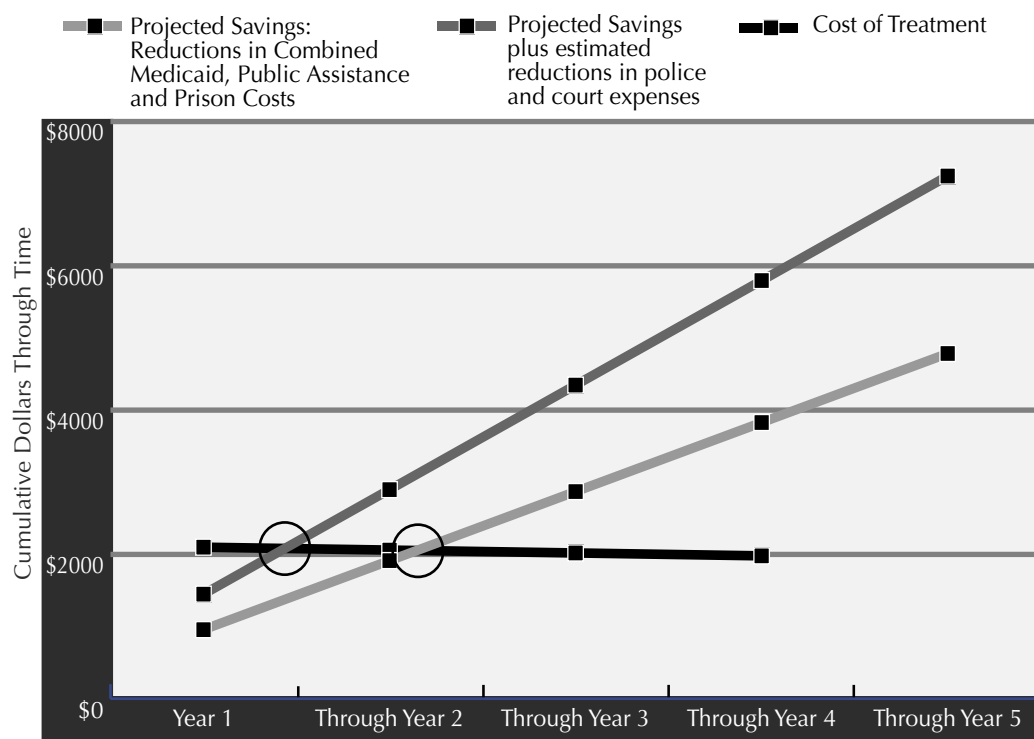


Source: Luchansky, B., & Longhi, D. *Cost Savings in Medicaid Expenses: An Outcome of Publicly Funded Chemical Dependency Treatment in Washington State: A Five-Year Cost Savings Study of Indigent Persons Served by Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, 1997.

This graph indicates striking savings in medical expenses for ADATSA patients, with Medicaid medical expenses prior to admission, in the five years following chemical dependency treatment. Overall savings totaled \$7,900 — \$2,300 in hospital inpatient, and \$5,600 in medical outpatient expenses.¹ Chemical dependency treatment is a wise investment, both in the health of ADATSA patients, and in reducing overall health expenses.

¹ Luchansky, B., & Longhi, D., *Cost Savings in Medicaid Expenses: An Outcome of Publicly Funded Chemical Dependency Treatment in Washington State: A Five-Year Cost Savings Study of Indigent Persons Served by Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)*. Olympia, WA: Washington State Department of Social and Health Service, Research and Data, Analysis, 1997.

Chemical Dependency Treatment Provided to ADATSA Patients Results in Reduced Costs to the Public Over a Five-Year Follow-Up Period.



Source: Luchansky, B., & Longhi, D. *Cost Savings in Medicaid Expenses: An Outcome of Publicly Funded Chemical Dependency Treatment in Washington State: A Five-Year Cost Savings Study of Indigent Persons Served by Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, 1997.

This five-year comparison of projected incremental savings with projected treatment costs for ADATSA (Alcoholism and Drug Addiction Treatment and Support Act) patients shows that the overall incremental savings are \$7,200, while the cumulative treatment costs total \$1,940. This means that every additional dollar spent on the treatment group results in \$3.71 in savings by the end of the five-year period. When estimated reductions in police and court expenses are added to the projections, the break-even point between costs and savings occurs much sooner. Additional funds spent on treatment pay for themselves in just over one year.

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Profile of Supplemental Security Income (SSI) Recipients Receiving Publicly Funded Chemical Dependency Treatment in Washington State

Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.

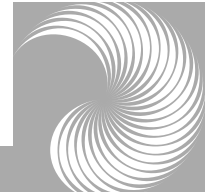
A profile of SSI recipients admitted to publicly funded chemical dependency treatment in Washington State in SFY 2003 reveals the following characteristics at time of admission:¹

<i>Number of Individuals Admitted:</i>	1,873
<i>Median Age:</i>	47
<i>Gender:</i>	58% Male; 43% Female
<i>Employment Status:</i>	Employed (full- or part-time or temporary) – 3%; Unemployed – 96%
<i>Primary Drug:</i>	Alcohol – 50; Heroin – 6%; Marijuana – 12%
<i>Criminal Justice Involvement:</i>	34% arrested at least once in previous year
<i>% with Children in the Home:</i>	22%
<i>Housing Status:</i>	11% homeless*

* Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.

¹ Data include unduplicated admissions to treatment; detoxification, transitional housing, private-pay, and Department of Corrections patients are excluded.

Chemical Dependency Treatment Lowers Medical Costs and is Associated with Better Criminal Justice Outcomes Among Supplemental Security Income (SSI) Recipients.*



The Department of Social and Health Services' Research and Data Analysis Division examined medical and chemical dependency treatment records for nearly 129,000 adult Supplemental Security Income (SSI) recipients to determine need for and receipt of chemical dependency treatment services.¹ Some 16% were found to be in need of treatment, and, of these, 50% received chemical dependency treatment between July 1997 and December 2001.

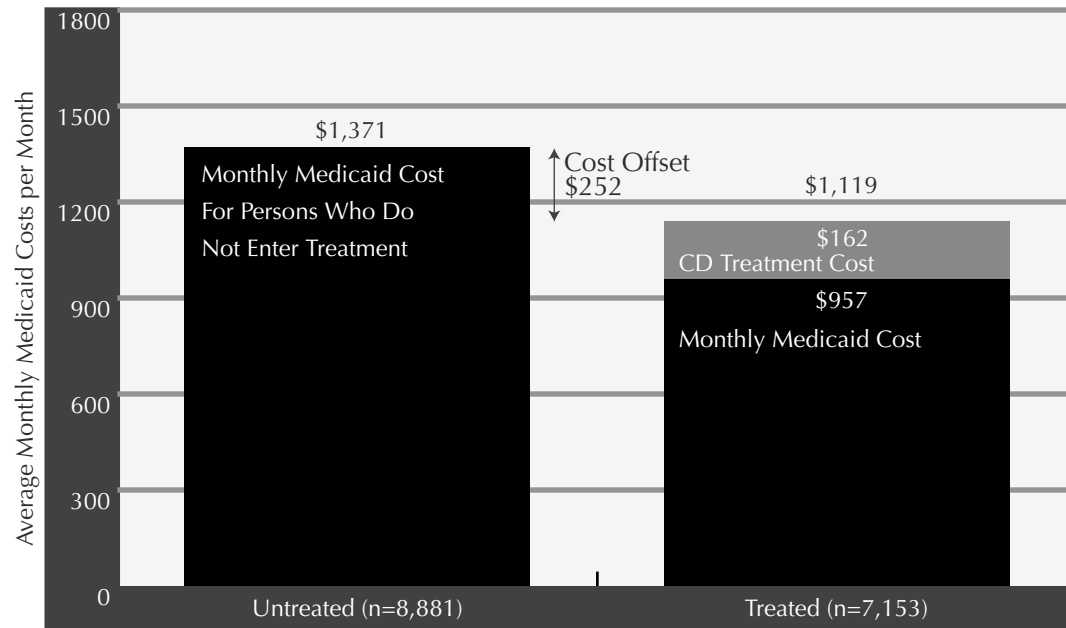
Medical, mental health, and nursing home cost differences between those who received treatment and those who did not were measured. After adjusting for age, race, sex, and prior medical expenses, and also subtracting costs of chemical dependency treatment (including detoxification), average monthly costs were \$252 higher per month for individuals who did not receive treatment than for those who received at least some treatment. The differential was even greater for those completing chemical dependency treatment.

If an additional 30% of the 10,572 SSI recipients in need of chemical dependency treatment were to receive it, annual medical cost savings would amount to approximately \$9.6 million.

In addition, chemical dependency treatment for SSI recipients was associated with better criminal justice outcomes: for those who completed treatment, a 43% reduced likelihood of arrest; a 38% reduced likelihood of any conviction; and a 48% reduced likelihood of a felony conviction.

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Chemical Dependency Treatment is Associated with Significantly Lower Medical Costs Among Supplemental Security Income (SSI) Recipients.



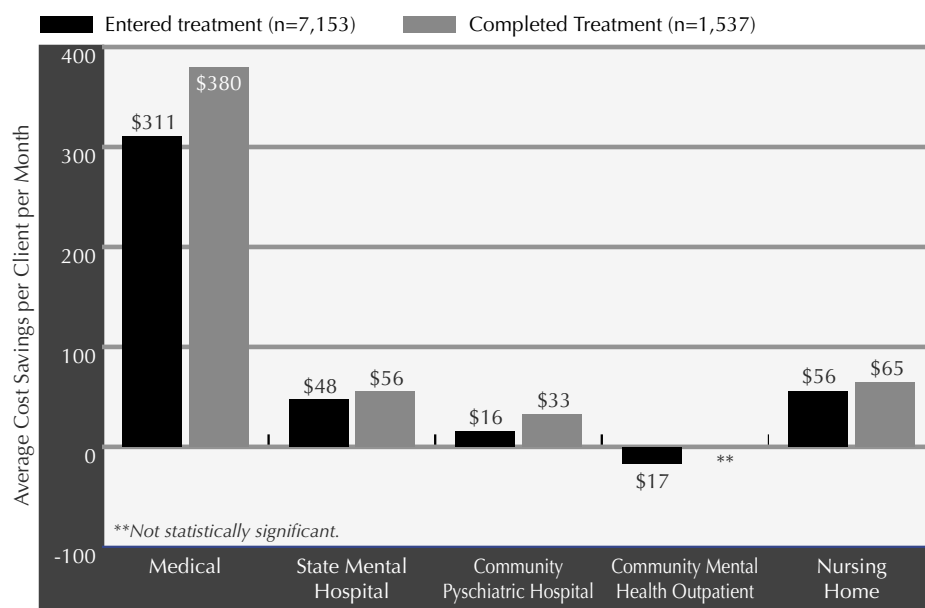
Source: Estee, S. & Nordlund, D., *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report*. Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

Medical and chemical dependency treatment records for nearly 129,000 adult Supplemental Security Income (SSI) recipients were examined to determine the need for, and receipt of, chemical dependency treatment services. Of these recipients, 16% were in need of treatment, and 50% of those in need received treatment between July 1997 and December 2001.

Medicaid costs differences – including medical, mental health, and nursing home costs – between those who received chemical dependency treatment and those who did not were measured. After adjusting for age, race, sex, and prior medical costs, the average monthly medical costs were \$414 per month higher for those who did not receive treatment. Even after including the cost of chemical dependency treatment, there was a net cost offset of \$252 per month or \$3,024 a year. The net cost offset rose to \$363 per month per client for those who completed treatment.¹

¹ Estee, S. & Nordlund, D., *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

Chemical Dependency Treatment is Associated with Significantly Lower Medical Costs Among Supplemental Security Income (SSI) Recipients.*



Source: Estee, S. & Nordlund, D., *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report*. Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

Medical and chemical dependency treatment records for nearly 129,000 adult Supplemental Security Income (SSI) recipients were examined to determine the need for, and receipt of, chemical dependency treatment services. Of these recipients, 16% were in need of treatment, and 50% of those in need received treatment between July 1997 and December 2001.

Medicaid costs differences – including medical, mental health, and nursing home costs – between those who received chemical dependency treatment and those who did not were measured. After adjusting for age, race, sex, and prior medical costs, there were found to be significant savings in medical, mental health, and nursing home costs. Overall reductions were \$414 per month per client for those who entered chemical dependency treatment compared with those in need of treatment but who did not receive it, and even higher (\$530 per month) for those who completed treatment.¹

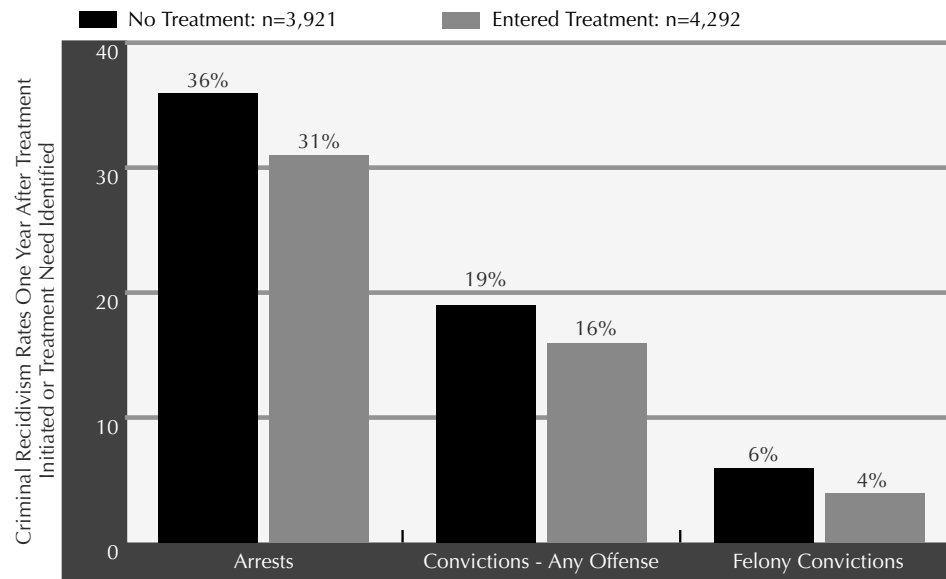
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¹ Estee, S. & Nordlund, D., *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.



Chemical Dependency Treatment is Associated with Fewer Criminal Arrests and Convictions Among Supplemental Security Income (SSI) Recipients.*

Criminal Recidivism Rates One Year After Treatment Initiated or Treatment Need Identified



Source: Estee, S. and Nordlund, D., *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project – 2002 Progress Report*. Washington Department of Social and Health Services, Research and Data Analysis Division, February 2003.

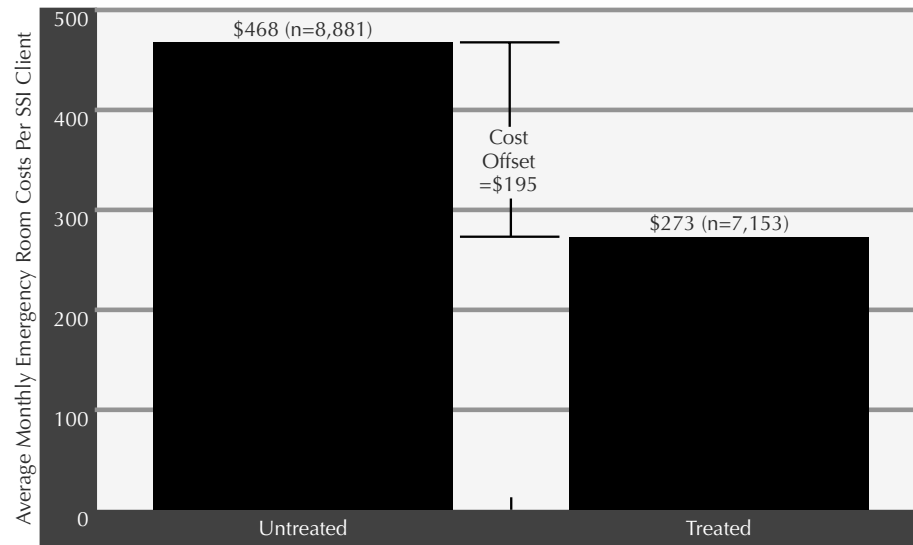
The Department of Social and Health Services' Research and Data Analysis Division examined criminal arrest and conviction and chemical dependency treatment records for nearly 129,000 adult Social Security Income (SSI) recipients.¹ Some 8,743 SSI recipients were found to have an arrest or conviction in the two years prior to initiating chemical dependency treatment or having a need for such treatment indicated. In the following year, those who entered treatment were found to be 16% less likely to have been arrested, and 34% less likely to have a felony conviction compared to those who did not enter treatment. Similarly, among clients who entered chemical dependency treatment and had a recent record of arrest or conviction, those who completed chemical dependency treatment were 43% less likely to be arrested, and 48% less likely to be convicted of a felony.²

*Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.

¹ Estee, S. and Nordlund, D., *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project – 2002 Progress Report*. Olympia, WA: Department of Social and Health Services, Research and Data Analysis Division, February 2003.

² Percentages are based on multivariate proportional hazards models that take account of age, gender, and race/ethnicity. See *Ibid.*, pp. 31-35 for details.

Savings in Emergency Room Costs Associated with Chemical Dependency Treatment Provided to Supplemental Security Income (SSI) Recipients More Than Offsets the Cost of Treatment.*



Source: Nordlund, D., et al. "Chemical Dependency Treatment Reduces Emergency Room Costs and Visits: Washington State Supplemental Security Recipients." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

In a study of almost 124,000 Supplement Security Income (SSI) recipients between July 1997 and December 2001, it was found that average monthly emergency room costs for those who were in need of chemical dependency treatment and received it were \$195 lower than for those who needed treatment but did not receive it. The number of visits per year was 14% lower, and average cost per visit was 38% lower. The saving in emergency room costs alone more than offset the average monthly cost of chemical dependency treatment (\$162).

**Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.*

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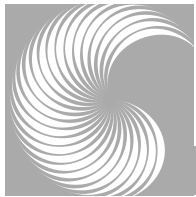
**Mentally Ill
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Addicted to
Methamphetamine

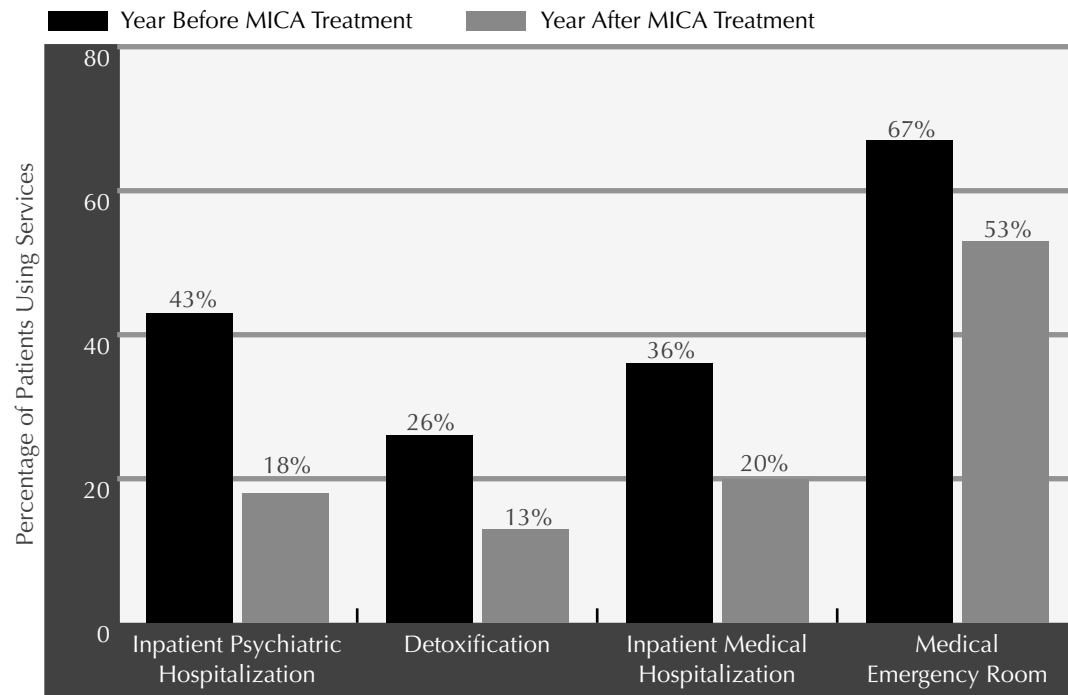
Low-Income
Patients

Patients Receiving
Opiate Substitution
Treatment

Patient
Satisfaction



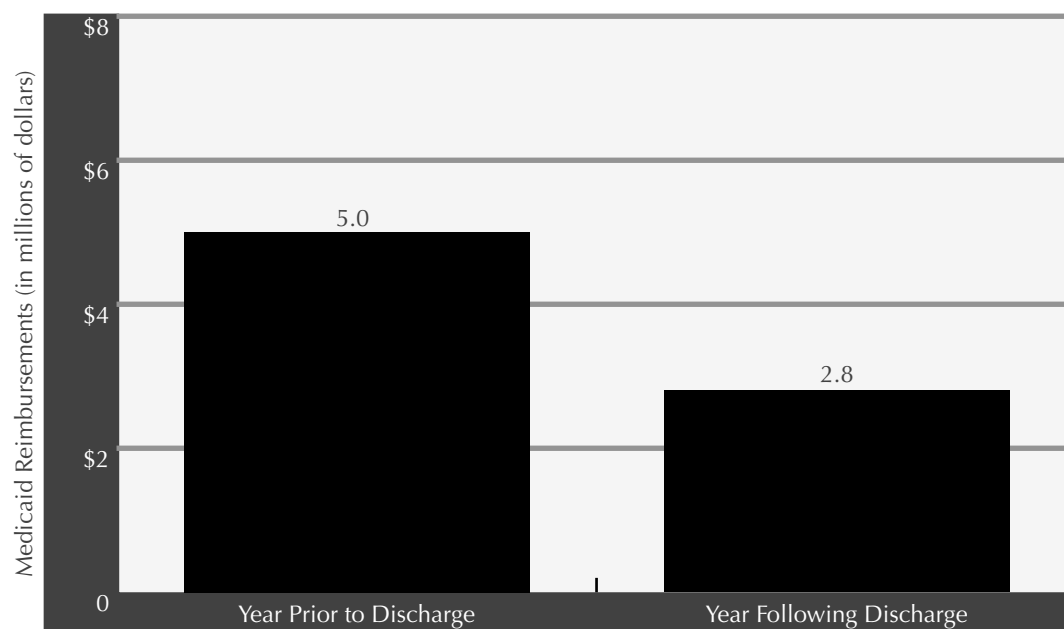
Mentally Ill Chemically Abusing Patients Utilize Fewer Medicaid Services Following Discharge from Residential Treatment.



Source: Maynard, C., et al. "Utilization of Services for Mentally Ill Chemically Abusing Patients Discharged from Residential Treatment," *The Journal of Behavioral Health Services & Research* 26(2), May 1999.

A significant number of Medicaid patients are diagnosed with both mental illness and substance abuse disorders. Treating these "co-occurring" disorders in an integrated manner has proven effective in enhancing health-related outcomes. This graph indicates that Medicaid expenses for patients with co-occurring disorders receiving coordinated services in a residential setting decreased overall by 44% in the year following discharge from the year prior to discharge.

Use of Expensive Acute Care Services Decreased for Mentally Ill Chemical Abusing Patients Following Discharge from Integrated Residential Treatment.



Source: Maynard, C., et al. "Utilization of Services for Mentally Ill Chemically Abusing Patients Discharged from Residential Treatment," *The Journal of Behavioral Health Services & Research* 26(2), May 1999.

Integrated mental illness/chemical dependency treatment has proven effective in reducing use of acute care services for mentally ill chemical abusing ("co-occurring") patients following discharge. The percentage of patients requiring inpatient psychiatric hospitalization fell by 58%; detoxification by 50%; inpatient medical hospitalization by 44%; and use of emergency rooms by 21% in the year following discharge.

Outcomes: The Benefits of Prevention & Treatment

**TREATMENT
OUTCOMES
FOR:**

Adolescents

Pregnant Women

ADATSA Patients

Supplemental
Security Income
Recipients

Mentally Ill
Chemically
Abusing Patients

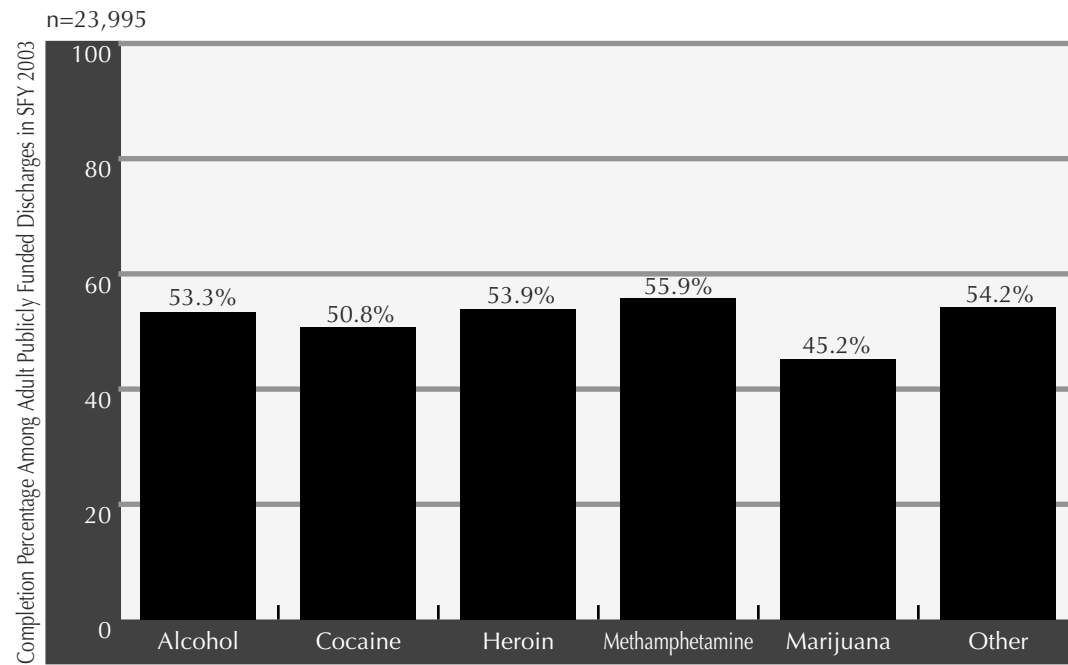
Individuals
Addicted to
Methamphetamine

Low-Income
Patients

Patients Receiving
Opiate Substitution
Treatment

Patient
Satisfaction

Adult Patients Addicted to Methamphetamine Complete Publicly Funded Chemical Dependency Treatment at Rates Similar to Patients Addicted to Other Substances.

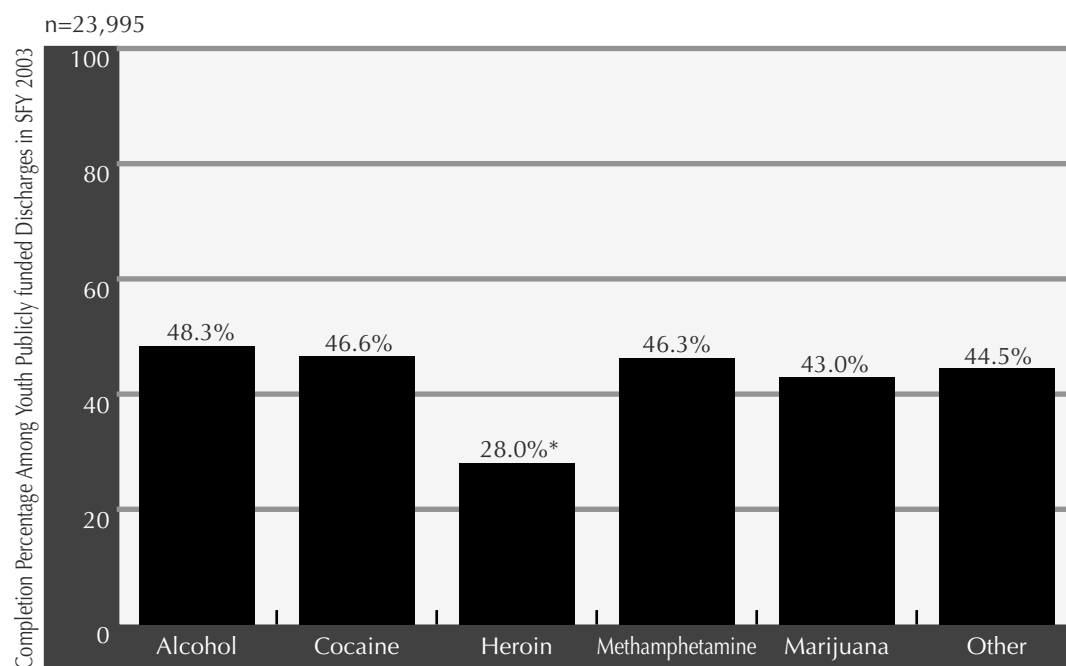


Source: DASA Treatment Analyzer, Washington State Division of Alcohol and Substance Abuse

This graph indicates that adults receiving publicly funded treatment for methamphetamine addiction complete treatment at rates similar to (actually slightly higher than) adults addicted to other drugs. This holds true across treatment modalities – intensive inpatient, intensive outpatient, outpatient, recovery house, and long-term residential treatment.

It should be noted that the majority of individuals addicted to methamphetamine are polydrug users.

Youth Patients Addicted to Methamphetamine Complete Publicly Funded Chemical Dependency Treatment at Rates Similar to Patients Addicted to Other Substances.



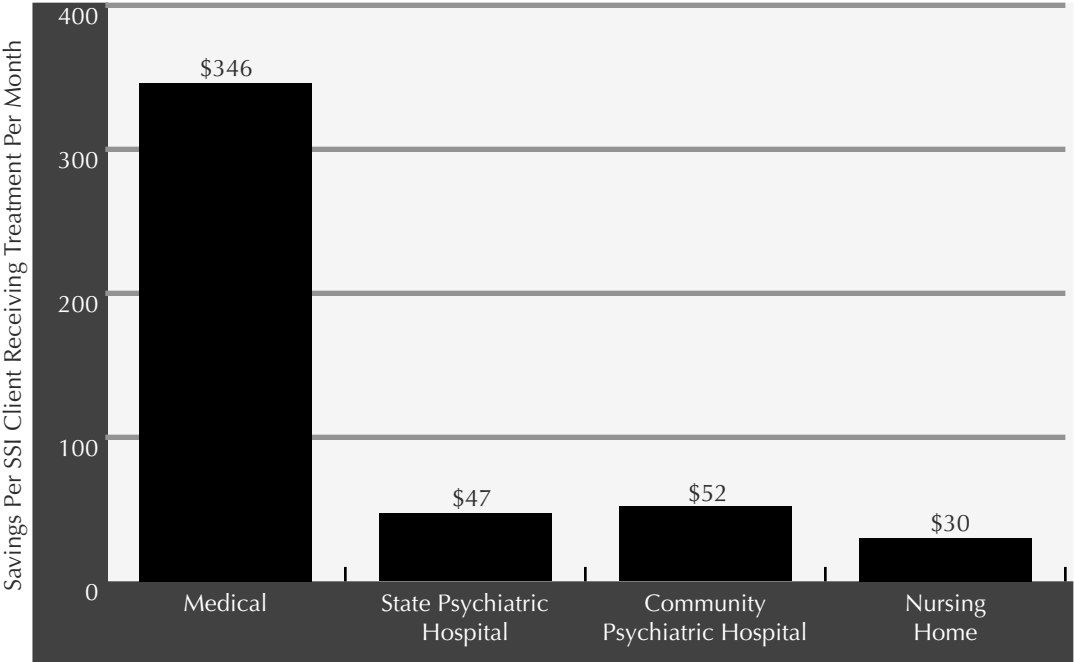
Source: DASA Treatment Analyzer, Washington State Division of Alcohol and Substance Abuse

*n = 7, not large enough for percentage to reach statistical significance.

This graph indicates that youth ages 12-17 receiving publicly funded treatment for methamphetamine addiction complete treatment at rates similar to youth addicted to other drugs. This holds true across treatment modalities – intensive inpatient, intensive outpatient, outpatient, recovery house, and long-term residential treatment.

It should be noted that the majority of youth addicted to methamphetamine are polydrug users.

Treatment of Stimulant Addiction, Including Methamphetamine Addiction, Results in Substantial Savings in Health Care Costs Among Supplemental Security Income Recipients.

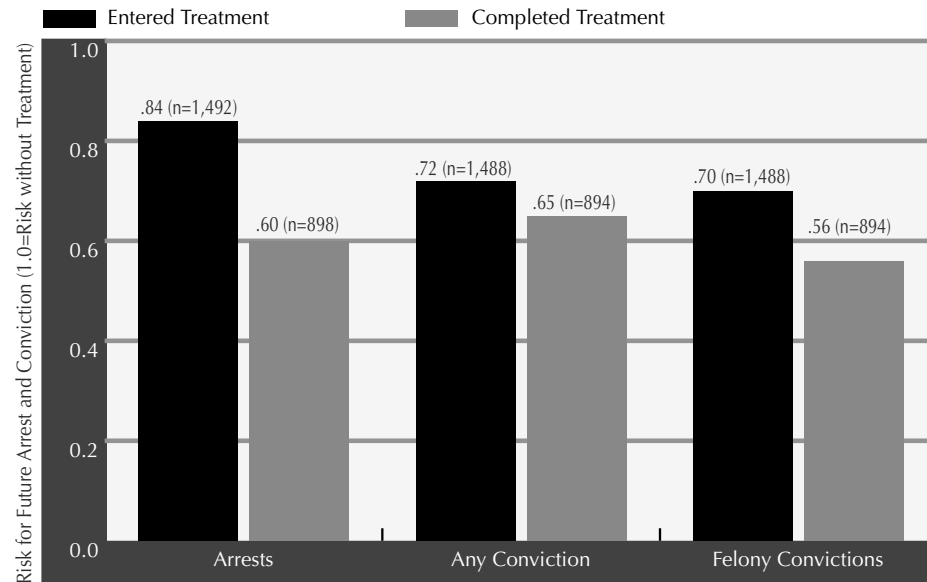


Source: Estee, S. & Nordlund, D. *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report*. Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

This graph indicates that there are substantial savings in health care costs for Washington State Supplemental Security Income (SSI) recipients who receive chemical dependency treatment for stimulant addiction (including methamphetamine addiction) compared with those who need such treatment but do not receive it. Even factoring in the cost of chemical dependency treatment (\$178 per month), the net savings in health care costs are \$296 per month or \$3,552 per year.

Providing treatment for stimulant (methamphetamine) addiction for SSI recipients in fact results in higher net cost savings (\$296/month) than treatment for addiction to other substances (\$267/month).

Treatment of Stimulant Addiction, Including Methamphetamine Addiction, Results in Reduced Risk for Arrest and Conviction Among Supplemental Security Income Recipients.*



Source: Estee, S. & Nordlund, D. *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report*. Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

This graph indicates that there are substantially reduced risks for arrest and conviction Washington State Supplemental Security Income (SSI) recipients who receive chemical dependency treatment for stimulant addiction (including methamphetamine addiction) compared with those who need such treatment but do not receive it. The risk of arrest is 16% for those who enter treatment, and 40% lower for those who complete treatment. The risk of felony conviction is 30% lower for those who enter treatment, and 44% lower for those who complete treatment. Chemical dependency treatment for those addicted to methamphetamine is thus a good investment in safer communities and lower criminal justice costs.

* Risks reflect results of proportional hazard models in which the effects of covariates on re-arrest or conviction rates (e.g., age, gender, race/ethnicity) are controlled.

Outcomes: The Benefits of Prevention & Treatment

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Adolescents

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Supplemental
Security Income
Recipients

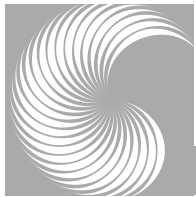
Mentally Ill
Chemically
Abusing Patients

Individuals
Addicted to
Methamphetamine

Low-Income
Patients

Patients Receiving
Opiate Substitution
Treatment

Patient
Satisfaction



Profile of Low-Income Adults Receiving Publicly Funded Chemical Dependency Treatment in Washington State

A profile of low-income adults admitted to publicly funded chemical dependency treatment in Washington State in SFY 2003 reveals the following characteristics at time of admission:¹

<i>Number of Individuals Admitted:</i>	20,225
<i>Median Age:</i>	34
<i>Gender:</i>	61% Male; 39% Female
<i>Employment Status:</i>	Employed (full- or part-time) – 19%; Unemployed – 81%
<i>Primary Drug:</i>	Alcohol – 50%; Stimulants (including Methamphetamine) - 18%; Marijuana - 13%
<i>Criminal Justice Involvement:</i>	72% arrested at least once in previous year
<i>% with Children in the Home:</i>	37%
<i>Housing Status:</i>	14% homeless*

* Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.

¹ July 2003. Data include unduplicated admissions to treatment; detoxification, opiate substitution, transitional housing, private-pay, and Department of Corrections patients are excluded.

Publicly Funded Residential Chemical Dependency Treatment Results in Improved Outcomes in Employment and Medical Status, Lower Substance Use and Higher Rates of Abstinence, and Reduced Criminal Activity.



A 1999 study was undertaken by the University of Washington's Alcohol and Drug Abuse Institute to assess the quality and effectiveness of the Division of Alcohol and Substance Abuse's publicly funded adult residential chemical dependency treatment system. Some 577 low-income patients were assessed at admission to treatment, and six months following their discharge. The study found:

- Patients were much less likely to use alcohol and illegal drugs following treatment. Self-reported abstinence rates for alcohol use in the past 30 days increased by 87%, and by 109% for drug use. Of those who continued to report any drug use, the percentage of patients who used any illegal drugs for seven or more of the past 30 days declined 74%, from 50% at treatment admission to 13% at follow-up.
- The average number of self-reported days of illegal activity declined 85%. Average 30-day earnings from illegal activity declined 93%, from \$485 at admission to \$32 at follow-up.
- In the 30 days prior to admission to treatment, only 19.8% of patients worked ten or more days. In the 30 days prior to the six-month post-discharge follow-up, 40.7% worked ten or more days, representing a 94% increase. Average monthly income increased from \$159 at admission to \$568 at follow-up.
- The percentage of patients reporting no days of medical problems during the past 30 days increased by 25% at the post-discharge follow-up. The number of days with mental health distress was reduced by 48%.
- The number of days with significant family conflict during the past 30 days declined by 62% at the post-discharge follow-up.¹



Profile of Adults Receiving Temporary Assistance for Needy Families Served By Publicly Funded Chemical Dependency Treatment Programs in Washington State

A profile of patients receiving Temporary Assistance for Needy Families (TANF) admitted to publicly funded chemical dependency treatment in Washington State in SFY 2003 reveals the following characteristics at time of admission:¹

<i>Number of Individuals Admitted:</i>	3,288
<i>Median Age:</i>	30
<i>Gender:</i>	26% Male; 74% Female
<i>Employment Status:</i>	Employed (full- or part-time) – 10%; Unemployed – 90%
<i>Primary Drug:</i>	Alcohol – 36%; Stimulants (including Methamphetamine) - 24%; Marijuana 21%
<i>Criminal Justice Involvement:</i>	54% arrested at least once in previous year
<i>% with Children in the Home:</i>	80%
<i>Housing Status:</i>	6% homeless*

A study of adults receiving TANF admitted to publicly funded chemical dependency treatment in Washington State, July 1998 – June 1999, indicated:

- One out of three women did not have a high school diploma or GED.
- Three out of four women reported they had been victims of domestic violence at some point in their lives.
- 21% reported receiving mental health treatment in the previous year.
- One out of three women reported using injection drugs at some point in the lives.²

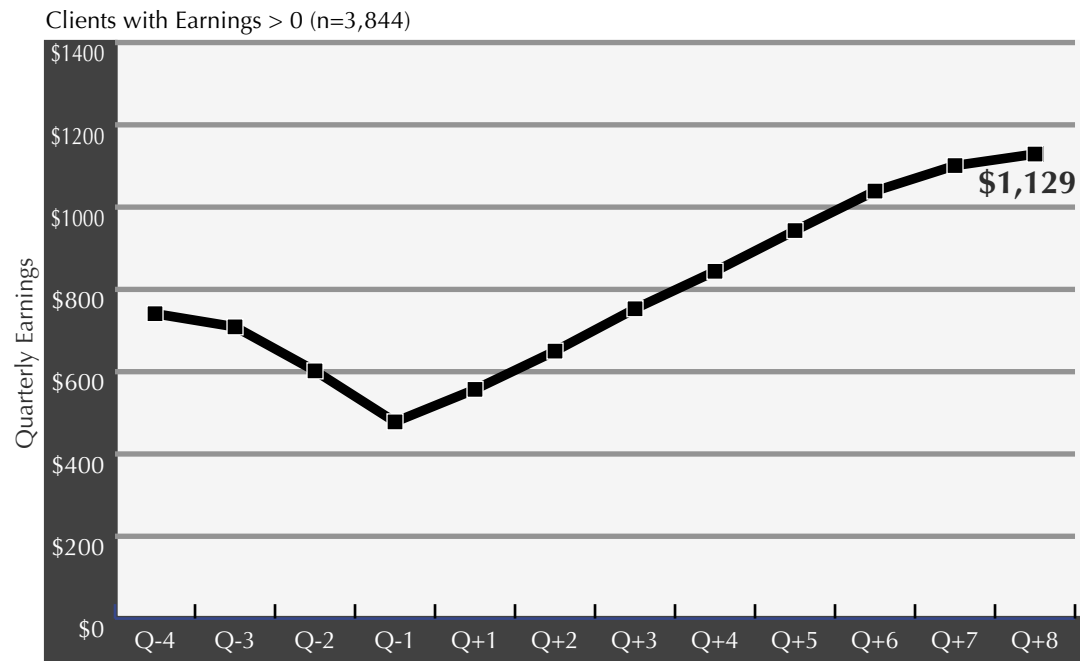
Research has shown that timely access to quality chemical dependency treatment can play a major role in moving individuals off public assistance and toward healthy lifestyles and self-sufficient lives.

* Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.

¹ Research and Evaluation Section, Washington State Division of Alcohol and Substance Abuse, July 2003. Data include unduplicated admissions to treatment; detoxification, transitional housing, private-pay, and Department of Corrections patients are excluded.

² Rodriguez, F. *Key Characteristics of TANF Adults Admitted to Publicly Funded Treatment in Washington State, July 1998 – June 1999*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2000.

AFDC Clients Who are Employed Show Major Increases in Earnings Following Chemical Dependency Treatment.



Source: Wickizer, T., et al. "Employment Outcomes Among AFDC Recipients Treated for Substance Abuse in Washington State," *The Millbank Quarterly* 78(4), 2000.

This graph indicates that chemically dependent clients receiving AFDC ("Aid to Families with Dependent Children") support showed marked declines in employment income in the year prior to receiving chemical dependency treatment, and more than doubled their average employment income in the two years following treatment. AFDC in Washington State has now been replaced by TANF ("Temporary Assistance for Needy Families"). This 2000 study confirms the results of earlier studies indicating that chemical dependency treatment assists low-income patients in moving toward self-sufficiency.

Outcomes: The Benefits of Prevention & Treatment

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Abusing Patients

Individuals
Addicted to
Methamphetamine

Low-Income
Patients

Patients Receiving
Opiate Substitution
Treatment

Patient
Satisfaction



Profile of Patients Receiving Publicly Funded Opiate Substitution Treatment in Washington State

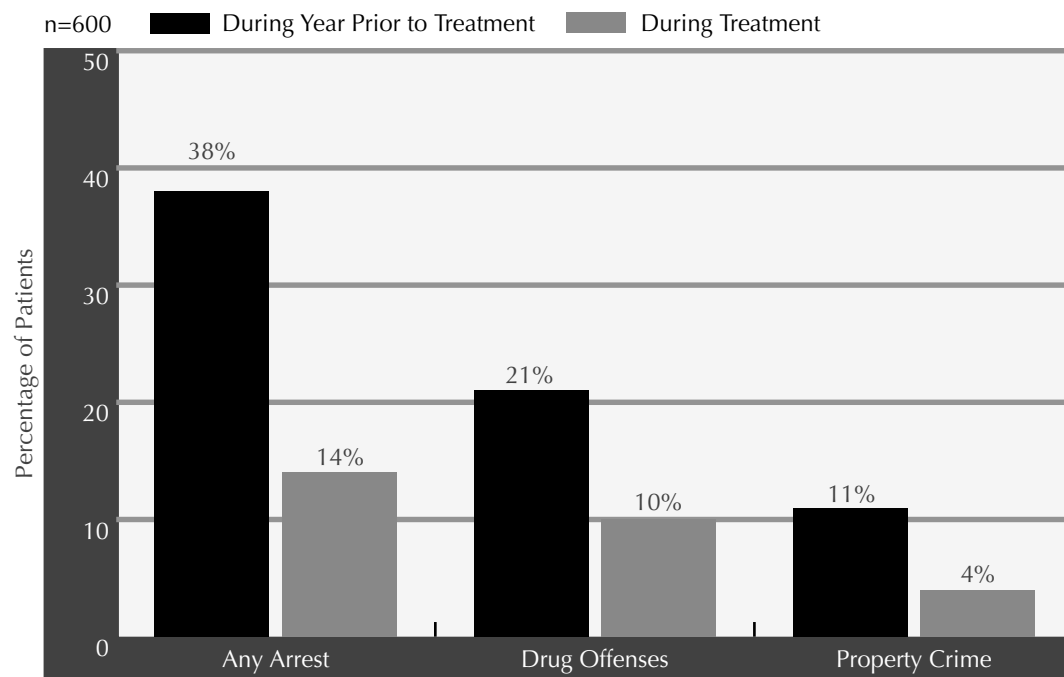
A profile of patients admitted to publicly funded opiate substitution treatment in Washington State in SFY 2003 reveals the following characteristics at time of admission:¹

<i>Number of Individuals Admitted:</i>	800
<i>Median Age:</i>	41
<i>Gender:</i>	46% Male; 54% Female
<i>Employment Status:</i>	Employed (full- or part-time or temporary) – 10%; Unemployed – 87%
<i>Primary Drug:</i>	Heroin – 91%; Other – 9%
<i>Criminal Justice Involvement:</i>	33% arrested at least once in previous year
<i>% with Children in the Home:</i>	26%
<i>Housing Status:</i>	14% homeless*

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

¹ Research and Evaluation Section, Washington State Division of Alcohol and Substance Abuse, July 2003. Data include unduplicated admissions to treatment; detoxification, opiate substitution, transitional housing, private-pay, and Department of Corrections patients are excluded.

Criminal Arrests Among Publicly Funded Opiate Substitution Patients Decreased During Treatment When Compared to the Year Prior to Treatment.



Source: Baxter, B., and Albert, D., *Report to the Legislature: Determining the Value of Opiate Substitution Treatment*, 2002.

This graph indicates that patients receiving publicly funded opiate substitution treatment are less likely to be arrested for a crime during treatment than in the year prior to treatment.

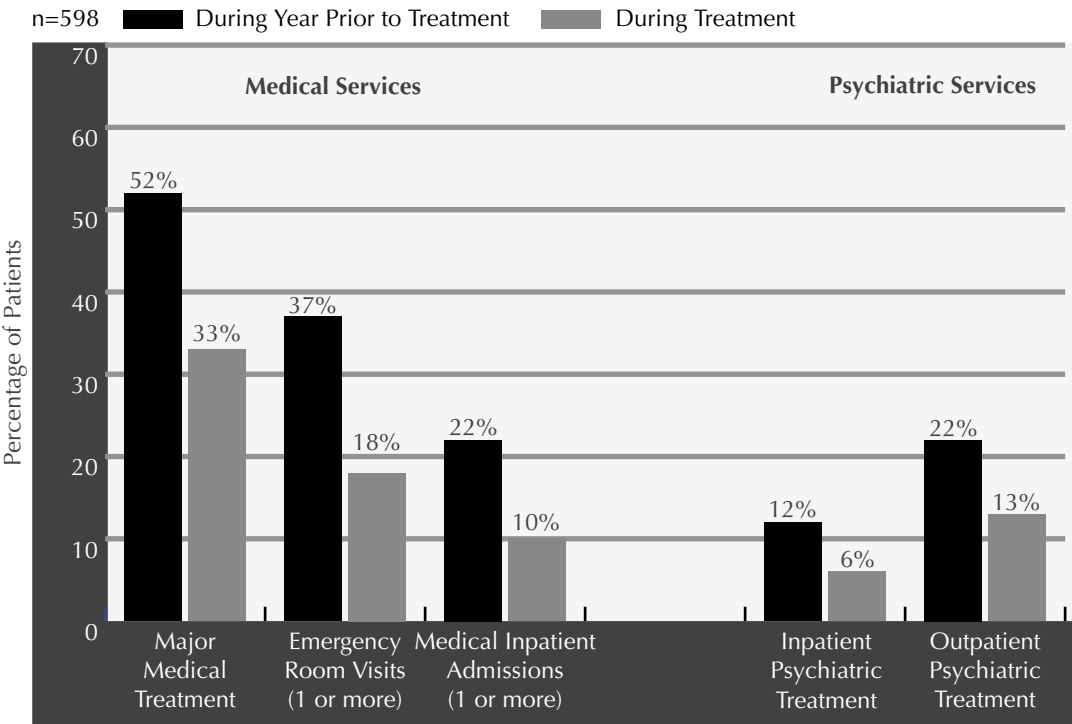
It is estimated that in 2000, almost 31,000 Washington State adults were in need of treatment for heroin addiction.¹ Sixteen opiate substitution clinics currently provide treatment through administration of methadone and delivery of counseling services. In addition, patients receive education, random urine drug screening to monitor drug use, and are subject to stringent rules regarding compliance. In SFY 2003, 4,923 patients were enrolled in opiate substitution programs in Washington State, 2,664 (54.1%) of whom were publicly funded.²

¹ Albert, D., *Determining the Value of Opiate Substitution Treatment*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, January 2004.

² Data do not include patients enrolled in Veterans Administration programs.



Health Care Utilization Among Publicly Funded Opiate Substitution Patients Decreased During Treatment When Compared to the Year Prior to Treatment.



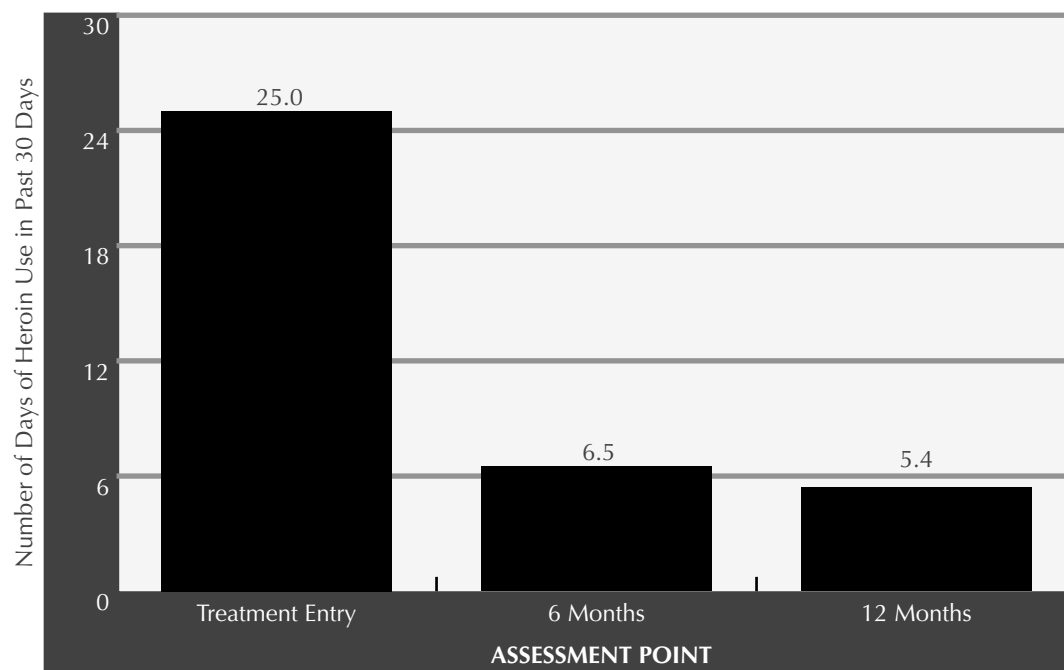
Source: Baxter, B., and Albert, D., *Report to the Legislature: Determining the Value of Opiate Substitution Treatment* - 2002.

Opiate substitution treatment has been scientifically shown to work. The federal Office of National Drug Control Policy called methadone therapy, “one of the longest-established, most thoroughly evaluated forms of drug treatment.”¹ A Consensus Panel convened by the National Institutes of Health in 1997 concluded, “Methadone treatment significantly lowers illicit opiate drug use, reduces illness and death from drug use, reduces crime, and enhances social productivity.”²

This graph indicates that patients receiving publicly funded opiate substitution treatment use fewer health care and psychiatric services during treatment than in the year prior to treatment. This results in significant cost savings throughout the health care system.

¹ Office of National Drug Control Policy, *The National Drug Control Strategy: 2000 Annual Report*. Washington, DC: Office of the White House, 2000.
² National Institutes of Health, *Effective Medical Treatment of Heroin Addiction: NIH Consensus Statement 1997*. November 17-19, 1997 15(6).

Patients Receiving Opiate Substitution Treatment Show Significant Decreases in Heroin Use.



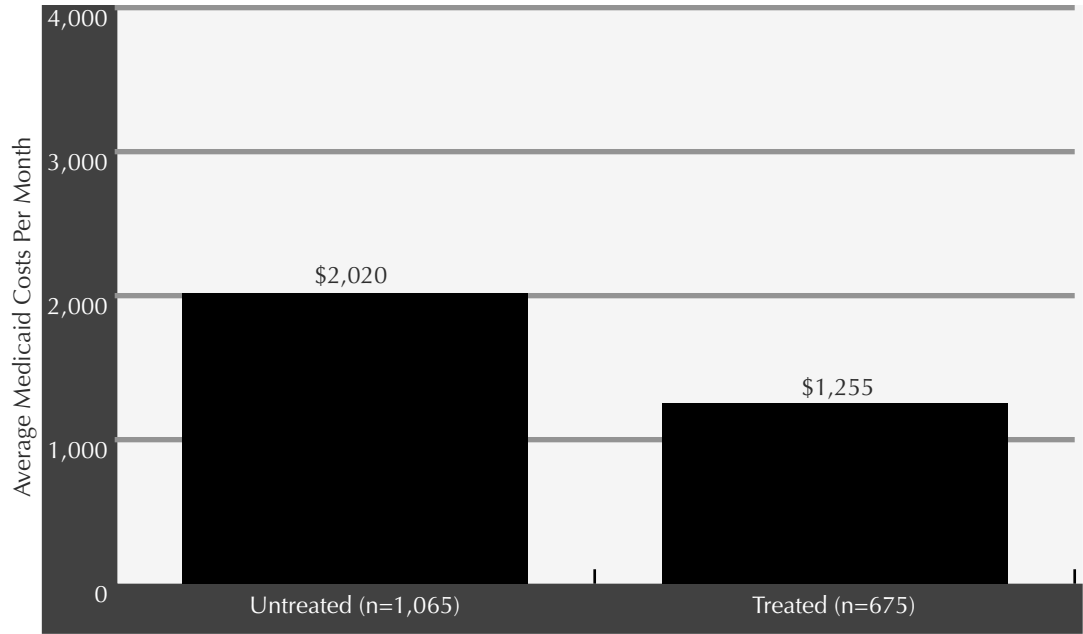
Source: Carney, M., et al., *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

A 2003 study of 135 patients admitted to publicly funded opiate substitution treatment in Washington State in 2000 demonstrated significant reductions in the average number of days they engaged in heroin use. At entry into treatment, patients reported an average of 25 days of heroin use in the past 30 days. At six months, this was reduced to 6.5 days, and at 12 months, to 5.4 days, representing a 78% decline. More than four out of five patients reported a reduction in the number of days using heroin at the six- and 12-month follow-ups.¹

¹ Carney, M., et al., *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.



Providing Methadone Treatment for Opiate-Addicted Supplemental Security Income Recipients Reduces Health Care Costs.



Source: Nordlund, D., et al., "Methadone Treatment for Opiate Addiction Lowers Health Care Costs and Reduces Arrests and Convictions." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

Medicaid-paid medical, mental health, and long-term care costs are significantly lower for Supplemental Security Income (SSI) recipients addicted to opiates who receive methadone treatment, compared to those who remain untreated. Even after the monthly cost of treatment (\$219/month) is included, the net cost savings per patient is \$765 per month, or a potential savings of \$9,180 per treated SSI recipient per year.

Savings are substantial (\$725/month) even for SSI recipients who are opiate-addicted even if they leave treatment with the first 90 days. However, for those who remain in treatment for at least one year, cost offsets rise to \$899 per month per recipient.

¹ Carney, M., et al., *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

Outcomes: The Benefits of Prevention & Treatment

**TREATMENT
OUTCOMES
FOR:**

Adolescents

Pregnant Women

ADATSA Patients

Supplemental
Security Income
Recipients

Mentally Ill
Chemically
Abusing Patients

Individuals
Addicted to
Methamphetamine

Low-Income
Patients

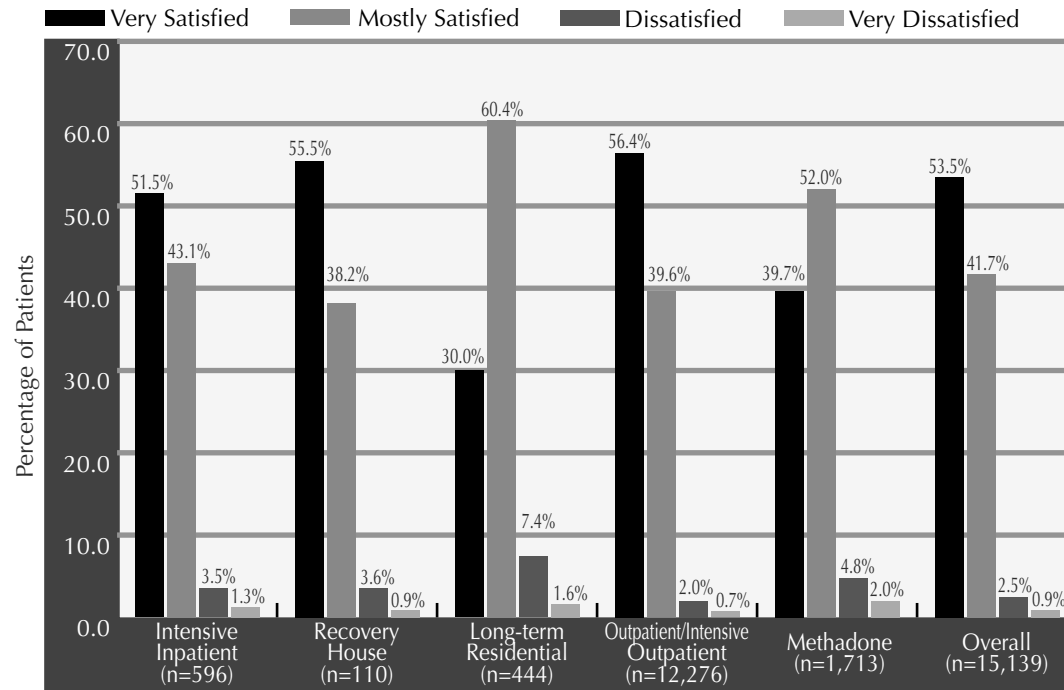
Patients Receiving
Opiate Substitution
Treatment

**Patient
Satisfaction**



In 2004, 95% of Adult Patients Receiving Chemical Dependency Treatment Services Reported Overall Satisfaction with the Services They Received.

“In an overall, general sense, how satisfied are you with the services you have received?”



Source: Rodriguez, F., *Clients Speak Out 2004: Fourth Annual Statewide Client Satisfaction Survey*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2004.

In March 2004, DASA conducted its fourth statewide client satisfaction survey. It was administered at 403 community-based treatment centers to 17,923 patients, or 7% of those receiving treatment in the participating agencies during the week of the survey.

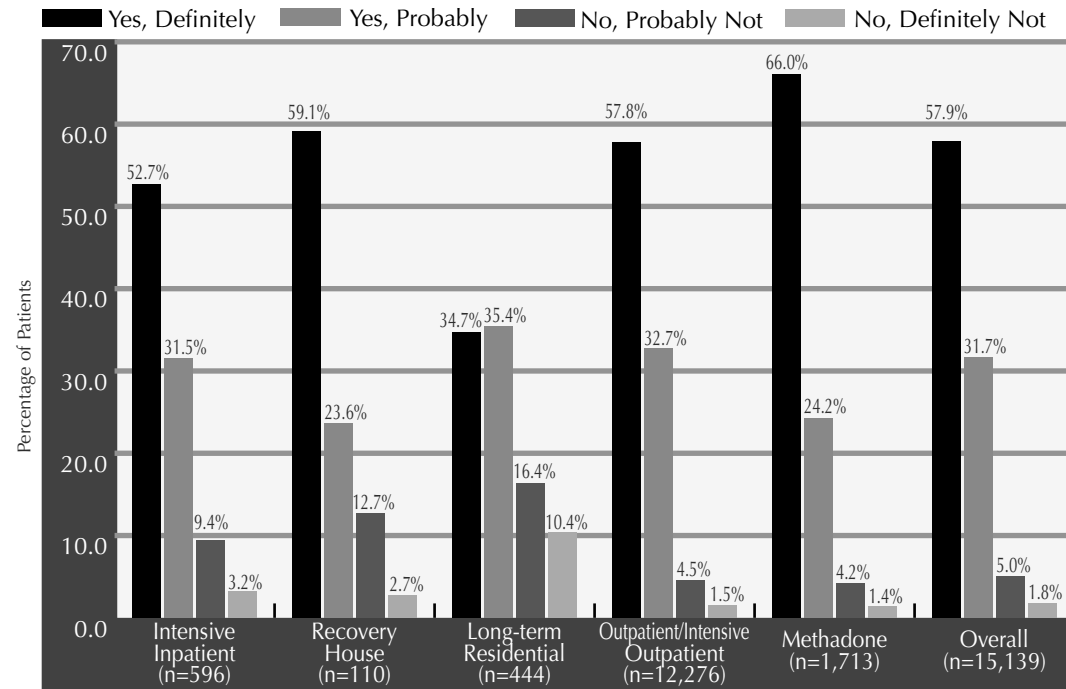
Overall, 95% of adult patients reported they were satisfied with the comfort and appearance of their treatment facility; 82% said they were always treated with respect by staff; 92% rated group sessions as helpful; and 86% reported they found individual counseling to be helpful.¹ Reports of responses to the survey were sent to each of the respective treatment agencies for use in quality improvement activities.

¹ Rodriguez, F., *Clients Speak Out 2004: Fourth Annual Statewide Client Satisfaction Survey*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2004.

In 2004, 90% of Adult Patients Receiving Chemical Dependency Treatment Services Reported They Would Return to the Same Program If They Needed Help Again.



“If you were to seek help again, would you come back to this program?”



Source: Rodriguez, F., *Clients Speak Out 2004: Fourth Annual Statewide Client Satisfaction Survey*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2004.

In March 2004, DASA conducted its fourth statewide client satisfaction survey. It was administered at 403 community-based treatment centers to 17,923 patients, or 75% of those receiving treatment in the participating agencies during the week of the survey.

Many patients receiving chemical dependency treatment services require other services as well. Treatment agencies play a key role in assisting patients in identifying and accessing these services. Of those reporting a need for them: 76% of adult patients said their treatment program was helpful in connecting them to legal services; 79% to medical services; 73% to family services; 73% to mental health services; 65% to educational or vocational services; and 55% to employment services.¹

Treatment Completion





Treatment Completion Improves Patient Outcomes

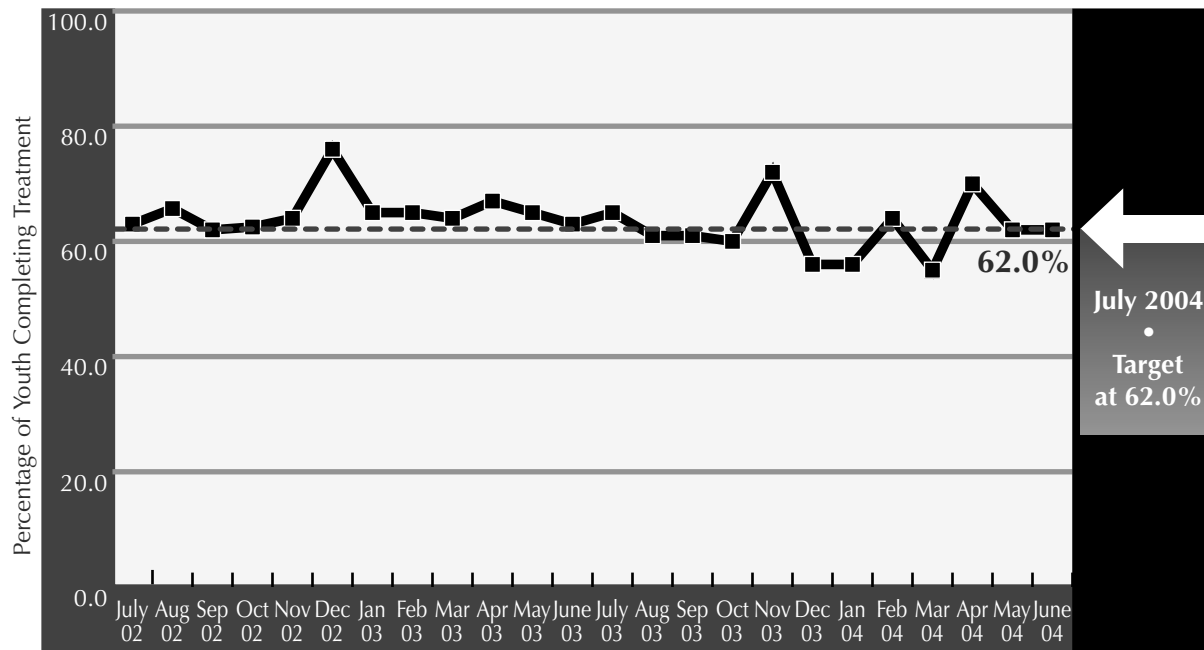
As part of the Department of Social and Health Services' pledge to ensure better outcomes for the state residents it serves, the Division of Alcohol and Substance Abuse (DASA) has committed itself to improving completion and retention rates for publicly funded patients receiving chemical dependency treatment.

Multiple studies, conducted in Washington State and elsewhere, demonstrate that outcomes following from treatment participation are significantly enhanced when patients complete treatment. For example, relative to patients who did not complete treatment, completers have been found to:

- Have higher employment and wages following discharge from treatment;
- Be arrested and convicted less frequently after discharge;
- Have significantly fewer inpatient medical hospital admissions and are less likely to require emergency medical services after discharge;
- If pregnant, are more likely to have full-term deliveries, babies with higher birth weights, and fewer fetal or infant deaths; and
- Produce higher cost savings to public systems following discharge.

In the pages that follow, results from studies that illustrate the above points are featured. All studies have been conducted in Washington State with publicly funded clients. Taken together, they suggest that improving treatment completion rates is one of the most powerful ways to maximize benefits from the limited public resources available to fund chemical dependency treatment. DASA is now working with researchers, counties, tribes, and both residential and outpatient treatment providers to set targets and incorporate best practices to improve completion rates throughout the state.

Residential Treatment Completion Rates for Youth are at the July 2004 Target of 62%.



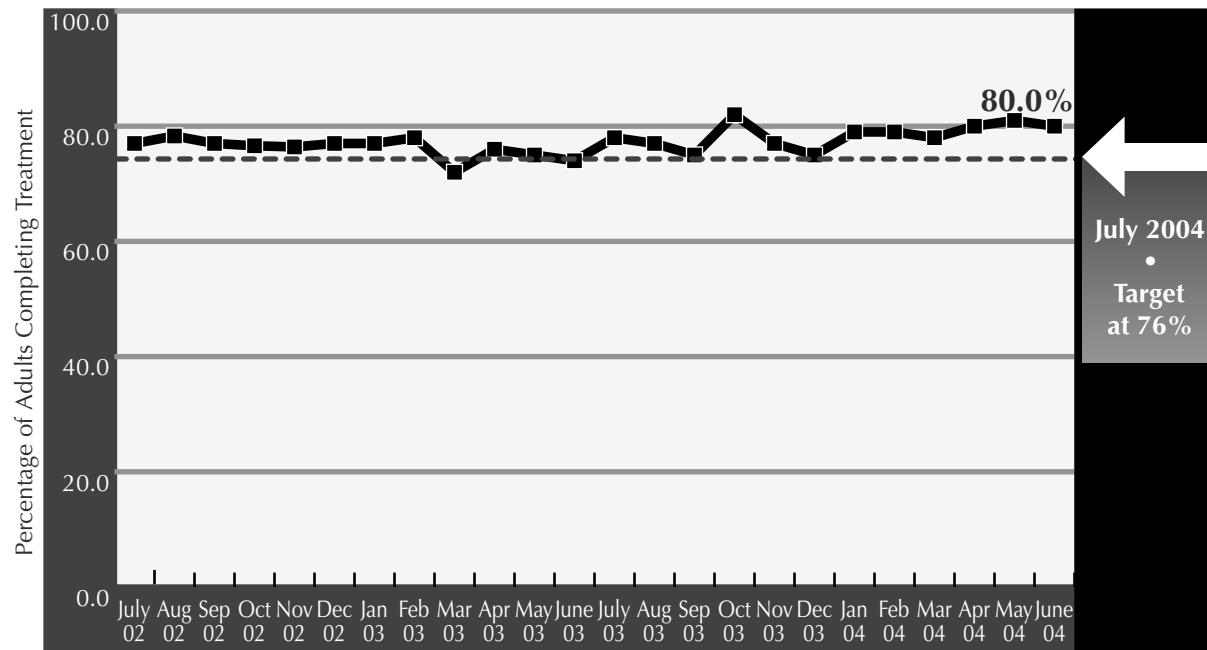
Source: Program Review, Division of Alcohol and Substance Abuse, June 2004.

The Division of Alcohol and Substance Abuse has set a goal of increasing the percentage of low-income and indigent youth who complete publicly funded chemical dependency treatment. Research has demonstrated that treatment completion is closely linked to better outcomes for both adults and youth. Cumulative data from July 2003-June 2004 indicate that 61.8% of low-income and indigent youth completed treatment.

Over the past year, the clinical severity of youth being treated in residential treatment programs has increased. A larger percentage of patients are being admitted to higher and more secure levels of care, and for longer length-of-stay.



Residential Treatment Completion Rates for Adults Now Consistently Exceed the July 2004 Target of 76%.



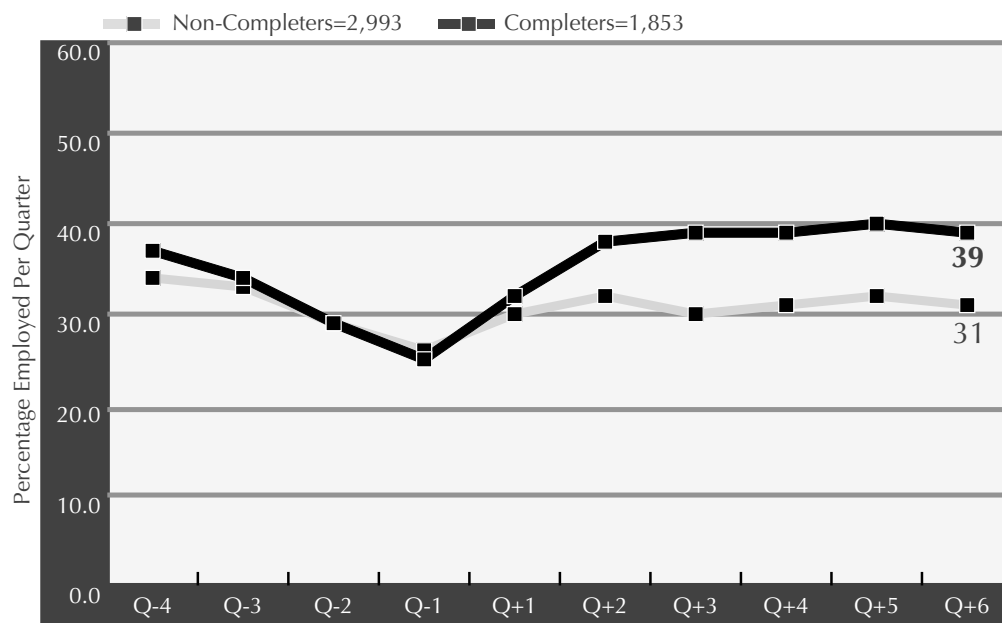
Source: Program Review, Division of Alcohol and Substance Abuse, June 2004.

The Division of Alcohol and Substance Abuse has set a goal of increasing the percentage of low-income adults who complete publicly funded chemical dependency treatment. Research has demonstrated that treatment completion is closely linked to better outcomes for both adults and youth. Cumulative data from July 2003-June 2004 indicate that 78.4% of low-income adults completed treatment.

Treatment Completers are More Likely to Become Employed After Treatment.



Percentage of ADATSA Patients Employed During the Four Quarters Before Admissions and Six Quarters After Discharge from Chemical Dependency Treatment

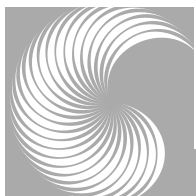


Source: Luchansky, B. and He, L., *Employment Outcomes of Chemical Dependency Treatment: Analyses from Washington State. An Interim Report.* 2002.

In a recent study of ADATSA patients¹, employment trends among treatment completers and non-completers were tracked. Prior to treatment, both completers and non-completers experienced declining rates of employment (see Quarters -4 through -1 on graph above). After treatment, employment rates rose for both groups, but the rise was significantly greater for completers: during the sixth quarter after treatment began, 39% of the completers were employed compared to 31% of the non-completers, representing a difference of 25.8%.²

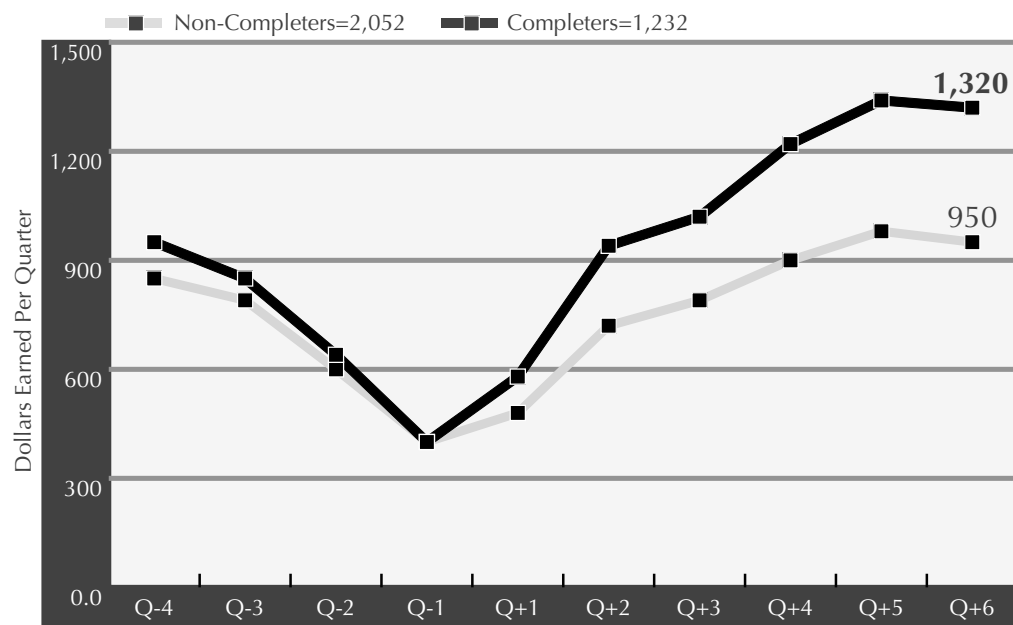
¹ ADATSA is a state-funded program that provides a continuum of care to persons who are indigent and deemed unemployable as a result of alcoholism and/or other drug addiction. ADATSA stands for the legislation that funds this program, the Alcoholism and Drug Addiction Treatment and Support Act.

² Luchansky, B. and He, L., *Employment Outcomes of Chemical Dependency Treatment: Analyses from Washington State. An Interim Report.* Olympia, WA: Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2002.



Treatment Completers Show Pronounced Post-Treatment Wage Increases.

Quarterly Wages for ADATSA Patients During Four Quarters Before Admission and Six Quarters After Discharge from Chemical Dependency Treatment



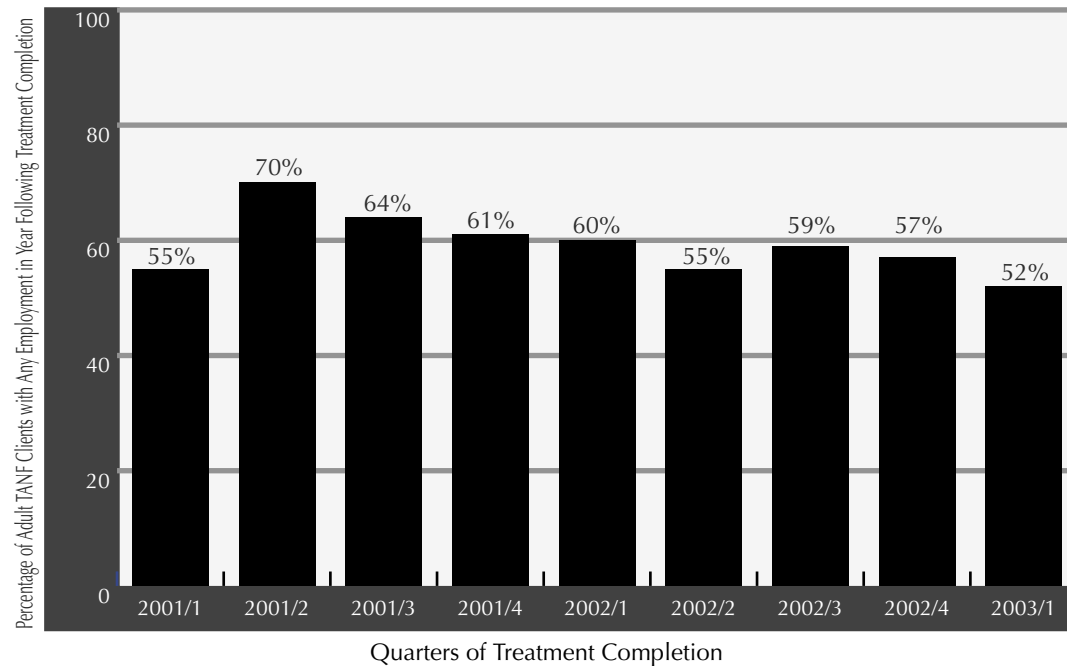
Source: Luchansky, B. and He, L., *Employment Outcomes of Chemical Dependency Treatment: Analyses from Washington State. An Interim Report.* 2002.

In a recent study of ADATSA patients¹, among those who were employed, it was found that pre-treatment wages for those who completed and those who did not complete chemical dependency treatment were similar. For both groups, wages began to decline four quarters before beginning treatment and continued to decline until treatment began. After treatment, wages rose for both groups. However, the increase in wages for treatment completers was more pronounced than for non-completers. During the sixth quarter after treatment began (see Q+6 on chart), completers earned \$1,316 on average, while non-completers earned \$941, a difference of \$375, representing a 39.8% difference.²

¹ ADATSA is a state-funded program that provides a continuum of care to persons who are indigent and deemed unemployable as a result of alcoholism and/or other drug addiction. ADATSA stands for the legislation that funds this program, the Alcoholism and Drug Addiction Treatment and Support Act.

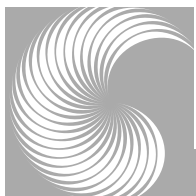
² Luchansky, B., and He, L., *Employment Outcomes of Chemical Dependency Treatment: Analyses from Washington State. An Interim Report.* Olympia, WA: Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2002.

More than Half of Adult Clients Enrolled in the Temporary Assistance for Needy Families (TANF) Program and Completing Publicly Funded Chemical Dependency Treatment Become Gainfully Employed in the Year Following Discharge.

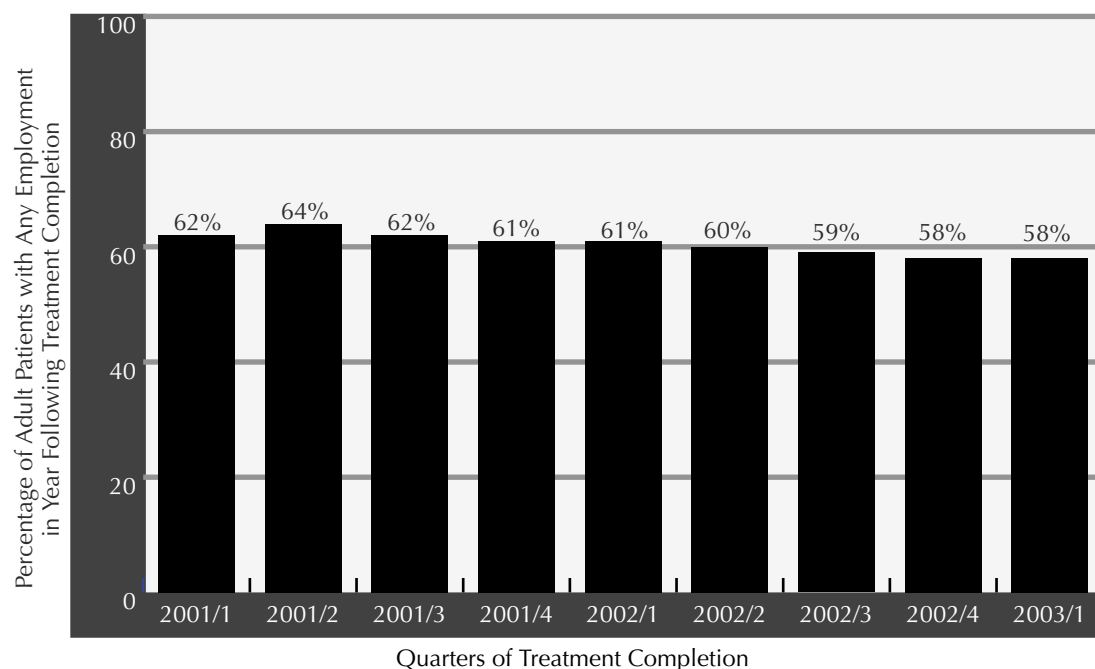


Source: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2004.

This graph indicates that of clients enrolled in the Temporary Assistance for Needy Families (TANF) program who completed chemical dependency treatment in the first quarter of SFY 2003, and did not require further treatment, 52% became employment in the following 12 months. Some 46% of those employed worked more than 20 hours a week; 46% earned wages above the Federal Poverty Level. For TANF clients with substance abuse problems, chemical dependency treatment helps move them toward economic self-sufficiency. However, in difficult economic climates, as this graph indicates, it becomes more difficult for TANF clients to gain employment.



Almost 60% of Adult Patients Completing Publicly Funded Chemical Dependency Treatment Become Gainfully Employed in the Year Following Discharge.



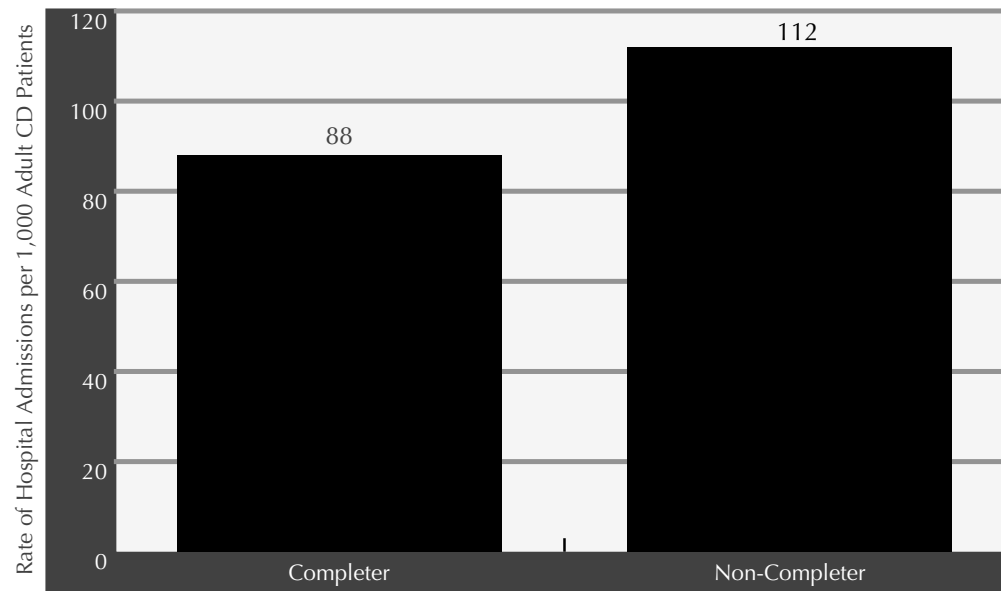
Source: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2004.

This graph indicates that almost three out of five adult low-income who completed chemical dependency treatment in the first quarter of SFY 2003, and did not require further treatment, 58% became employment in the following 12 months. Average monthly wages were approximately \$1,119. More than half of those employed (54%) worked more than 20 hours a week; 59% earned wages above the Federal Poverty Level. For TANF clients with substance abuse problems, chemical dependency treatment helps move them toward economic self-sufficiency.

Treatment Completers Had Lower Hospital Admission Rates Following Chemical Dependency Treatment.



Adjusted Rates of Hospital Admissions per 1,000 Patients in the Year Following a Treatment Episode



Source: Luchansky, B., et al., *Substance Abuse Treatment and Hospital Admissions: Analyses from Washington State, 2002*.

A study of almost 10,000 adult patients who received publicly funded chemical dependency (CD) treatment in 1995 showed that patients who completed CD treatment were 21% less likely to be admitted to a hospital in the year following discharge compared to patients who did not complete treatment.¹



Completion of Treatment and Treatment Retention are Associated with Reduced Risk of Felony Arrests Among Adults, and Convictions Among Youth.

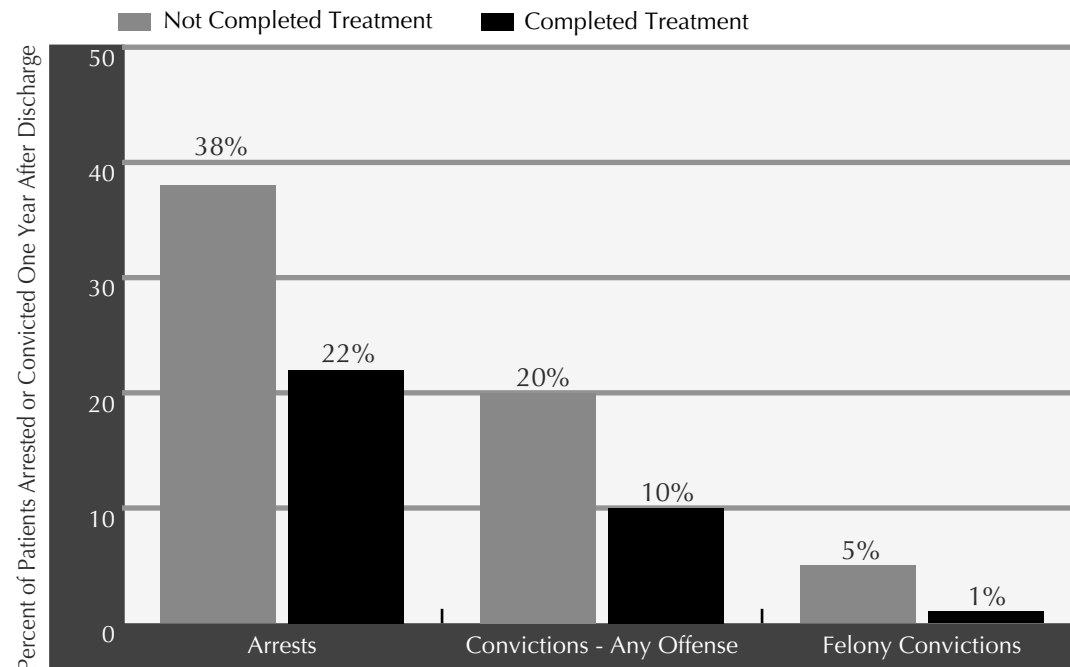
Research, both in Washington State and elsewhere, has consistently shown that admission to chemical dependency treatment is associated with lower crime rates, fewer arrests, and lower criminal justice costs. More recent studies highlight the benefits of both treatment completion and longer retention in treatment:

- A 2002 study of over 10,000 adult patients who received publicly funded chemical dependency treatment in 1995 demonstrated that the probability for a felony offense was 21% lower in the following year for patients completing treatment when compared to patients who did not complete treatment. For patients whose treatment episode was greater than 90 days, the probability of a felony arrest was 32% less than for patients with shorter treatment episodes.¹
- A 2003 study of almost 6,000 youth who participated in substance abuse treatment between 1997 and 1998 indicated that patients completing treatment had a 29% reduction in the risk of a subsequent felony conviction, and a 17% reduction in risk of any conviction in the year following discharge, compared to non-completers.²

¹ Luchansky, B., et al., *Substance Abuse Treatment and Arrests: Analyses from Washington State (Fact Sheet 4.42)*. Olympia, WA: Department of Social and Health Services, Research and Data Analysis Division, 2002.

² Luchanski, B., et al., *Treatment Readmissions and Criminal Recidivism in Youth Following Participation in Chemical Dependency Treatment*. Manuscript being prepared for publication, 2003.

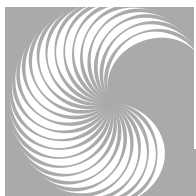
Treatment Completion was Associated with Reductions in Arrests and Convictions Among Supplemental Security Income Recipients.*



Source: Estee, S., & Nordlund, D., *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project – 2002 Progress Report*.

A study completed in 2003 indicates that Supplemental Security Income (SSI) recipients who completed chemical dependency treatment had lower rates of arrest, convictions for any type of offense, and felony convictions one year after discharge than those who did not complete treatment. Rates of arrest were 42% lower, rates of convictions 50% lower, and rates of felony conviction 80% lower.¹

* Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for Social Security Title II benefits. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.



Supplement Security Income Recipients Who Completed Chemical Dependency Treatment Had Lower Medical, Psychiatric, and Nursing Home-Related Costs than Those Who Did Not Complete Treatment.*

Source of Costs ¹	Treatment Completers	Treatment Non-Completers
Medical Costs	-\$380	-\$292
Mental Health Costs		
<i>State Hospital Costs</i>	-\$56	-\$46
<i>Community Psychiatric Hospital Costs</i>	-\$33	-\$11
Nursing Home Costs	-\$65	-\$53

Source: Estee, S., & Nordland, D. *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project – 2002 Progress Report*.

In a study of over 7,000 Supplemental Security Income (SSI) recipients who entered chemical dependency treatment, those who completed treatment had lower monthly medical, psychiatric, and nursing home costs, and hence higher monthly cost offsets than those who did not. Medical care expenses for SSI recipients who completed treatment were \$380 lower than the cost of medical care for those who needed chemical dependency treatment but remained untreated. SSI recipients who did not complete treatment also had lower costs, but by only \$292, or 22.4% less.²

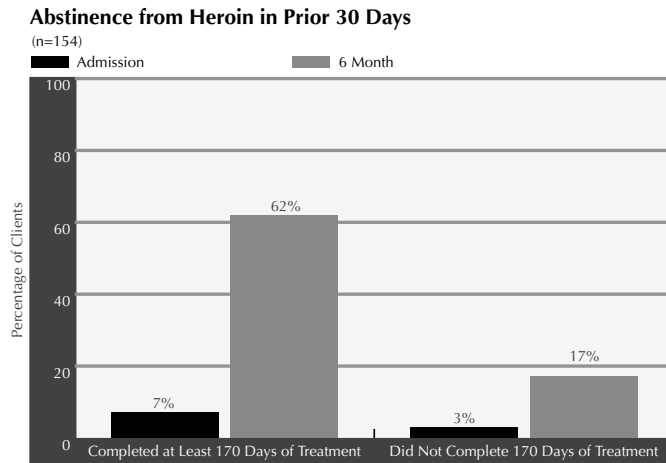
* Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for Social Security Title II benefits. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.

¹ Costs represent the adjusted average monthly per person difference in costs for SSI recipients receiving chemical dependency treatment compared to costs for those who needed treatment but did not get it.

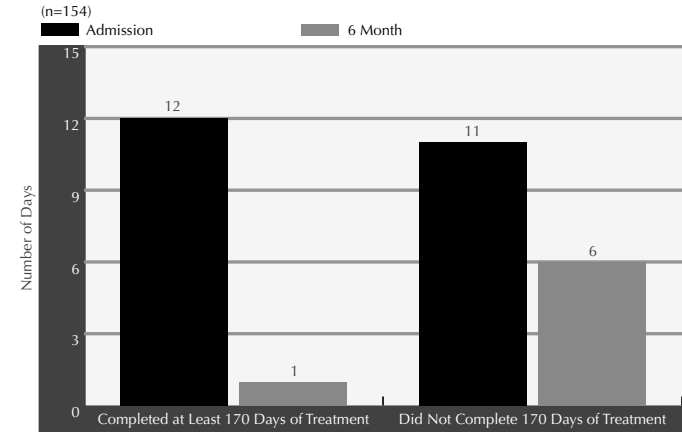
² Estee, S., & Nordlund, D. *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project – 2002 Progress Report*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, 2003.

Remaining in Treatment Results in Improved Outcomes Among Patients Receiving Methadone Treatment.

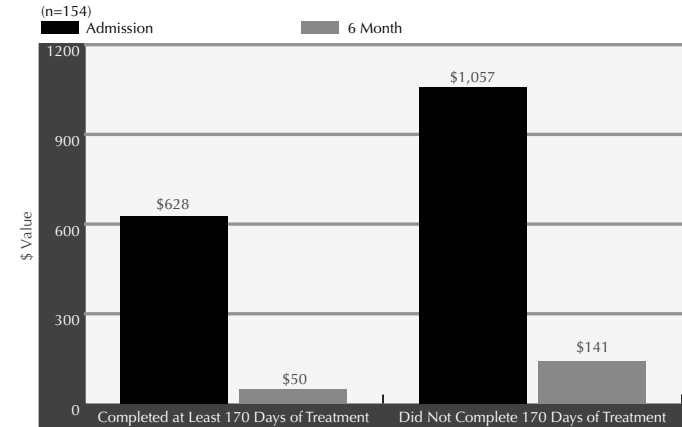
A 2001 study of 154 patients admitted to methadone treatment found that at a six-month follow-up, those who completed at least 170 days of treatment reported substantially higher rates of abstinence from heroin use, fewer days of illegal activity, and substantial decreases in money obtained through illegal activity.

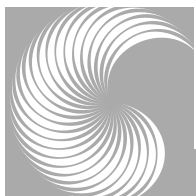


of Days Engaging in Illegal Activity in Prior 30 Days
(n=154)

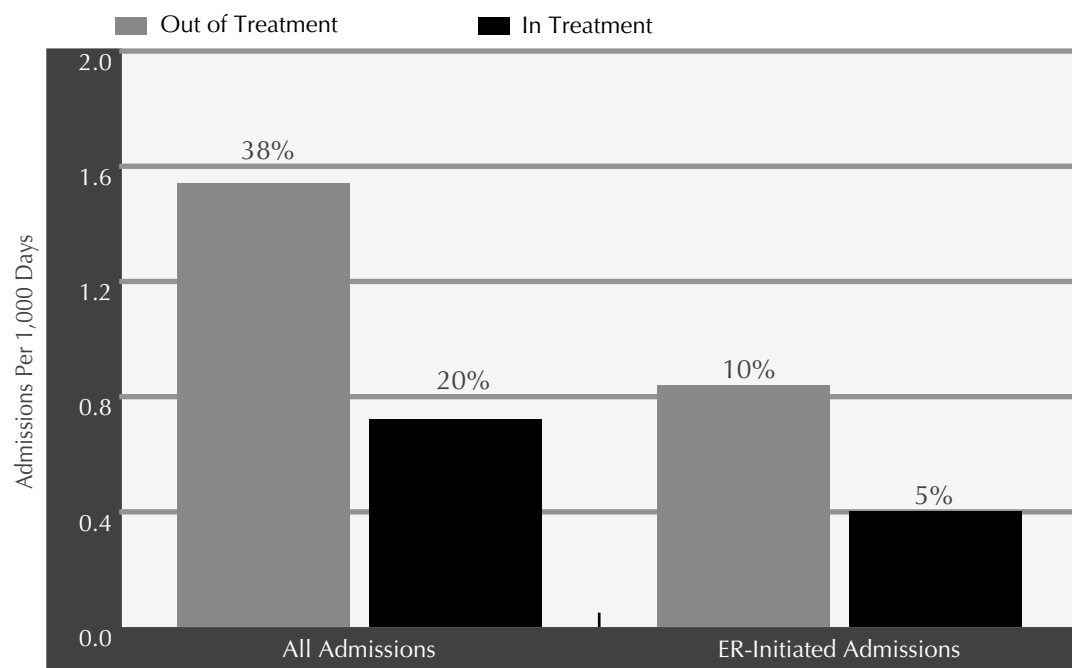


Average \$ from Illegal Sources in Prior 30 Days
(n=154)





Opiate Substitution Treatment Patients are Less Likely to Be Admitted to Hospitals While in Treatment.



Source: Luchansky, B., et al., *Substance Abuse Treatment and Inpatient Hospital Admissions for Clients in Opiate Dependency Treatment: Longitudinal Analyses from Washington State*. Manuscript being prepared for publication, 2003.

A recent study conducted for the Division of Alcohol and Substance Abuse reported that publicly funded opiate substitution treatment patients were significantly more likely to be admitted to a hospital while they were out of treatment as compared to when they were in treatment. Patients in treatment were 33% less likely to experience a hospital admission than those who left treatment. Most of the hospital admissions came through either the emergency room (56%) or through an urgent care facility (21%). Such acute care services are among the most costly. Medicaid or Medicare paid for 82% of these hospital admissions; only 15% were paid by a private payer.¹ Thus, retention in opiate substitution treatment results in better health for patients, and lower costs to the public.

¹ Luchansky, B., et al., *Substance Abuse Treatment and Inpatient Hospital Admissions for Clients in Opiate Dependency Treatment: Longitudinal Analyses from Washington State*. Manuscript being prepared for publication. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2003

Longer Retention in Opiate Substitution Treatment is Associated with Higher Methadone Dose.

	Average Peak Methadone	Average Number of Days in Treatment
Opiate Substitution Treatment Program #1	109 mg/day	284.2
Opiate Substitution Treatment Program #2	83.1 mg/day	193.5

Source: Carney, M., et al., *Washington State Outcomes Project: Opiate Study Sample. Final Report*. Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

Longer retention in opiate substitution treatment is associated with better outcomes: less crime and involvement with the criminal justice system, fewer medical hospitalizations and emergency room visits, lower medical costs, fewer psychiatric hospitalizations, and less reliance on public assistance.

A 2003 study of 135 individuals admitted to two Washington State opiate substitution treatment programs found a close association between average peak methadone dose and average number of days in treatment. Patients in the programs where average peak dose was 109 mg/day remained in treatment an average of 90.7 days longer than those in the program where average peak dose was 83.1 mg/day, a difference of 46.8%. In addition, it was found that patients whose peak methadone dose was less than 75 mg/day were significantly more likely to leave treatment prior to 170 days. The mean peak methadone dose for patients who left treatment prior to 170 days was 78.0 mg/day, compared with a peak dose of 104.6 mg/day for those who remained in treatment at least 170 days.¹

¹ Source: Carney, M., et al., *Washington State Outcomes Project: Opiate Study Sample. Final Report*. Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

The Future: Policy Issues Confronting Washington State

ISSUES

Alcoholism as a
Chronic Disease

Brief Interventions
in Emergency Dept.
& Health Care Settings

Criminal
Justice

Opiate
Substitution
Treatment

Substance
Abuse and
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Treatment for
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Alcohol consumption in Washington State is at its lowest point in more than two decades. At the same time, chronic drinking rates are at the highest point in more than a decade, as are deaths due to chronic liver disease and cirrhosis. Alcohol abuse and alcoholism remain the number one substance abuse problem in Washington State. Alcoholism bears strong similarities to other chronic health problems such as asthma, diabetes, and high blood pressure.

Per capita alcohol consumption, both in Washington State and the nation, has been dropping steadily since 1980. In Washington State, most of that reduction has been in the consumption of hard liquor.¹ Yet at the same time, chronic drinking rates among Washington State adults appear to be on the rise, and the state has had a consistently higher alcohol-induced death rate than the nation. Deaths due to chronic liver disease and cirrhosis, closely associated with long-term alcohol use, are at their highest point in a decade. The total social and economic costs of alcohol abuse and alcoholism in the United States, estimated at \$184.6 billion, are approximately 50% greater than costs related to abuse of all illicit drugs combined.²

Shorter-Term Problems

Problems associated with alcohol use can be divided, although not cleanly, into those associated with shorter-term and longer-term, or chronic, use. Alcohol abuse -- either short-term, intermittent, or binge drinking -- is linked with deaths from traffic crashes, falls, fires, and drowning. It is also associated with homicide, suicide, domestic violence, family disruption, and child abuse.³ Binge drinking is also directly related to alcohol poisoning and blackouts. Intermittent use during pregnancy is associated with fetal and infant deaths, low birth weight births, and fetal alcohol syndrome and fetal alcohol effects. Light and moderate alcohol use is associated with 60% of alcohol-related absenteeism, lower worker productivity, and workplace accidents.⁴

Alcoholism as a Chronic Disease

Among young people, alcohol use is also associated with negative academic performance. Students who drink are more likely to have lower grades, cut classes, become truant, and are much more likely to drop out of school. Studies indicate that alcohol-dependent teens manifest impaired memory, altered perceptions of spatial relationships, and verbal skill deficiencies. Young people are also more likely to sustain brain damage as a result of alcohol abuse.⁵ According to a recent study published in the *Journal of the American Medical Association*, underage drinkers account for 19.7% of all alcohol consumed in the United States.⁶

Alcoholism – Associated Medical Problems

Of the approximately 17.6 million Americans who abuse alcohol, some 7.9 million (almost 45%) suffer from alcoholism, a chronic disease, characterized both by addiction and association with a long list of medical problems affecting virtual every organ system in the body.⁷ These include:

- High blood pressure (hypertension);
- Large red blood cell anemia;
- Decreased production and efficiency of white cells;
- Decreased production of clotting factors and platelets;
- Heart rhythm irregularities (arrhythmias);
- Heart muscle disorders (cardiomyopathy);
- Heart attacks;
- Stroke;
- Cancers of the mouth, pharynx, larynx, and esophagus;
- Breast cancer;

- Ulcers and gastritis;
- Gastro-esophageal hemorrhage;
- Impaired immune system, leading to increased susceptibility to infections, including pneumonia, tuberculosis, and septicemia;
- Cirrhosis;
- Acute and chronic inflammation of the pancreas;
- Worsening symptoms of mental illness and interference with treatment;
- Compromised sexual function; and
- Reduced bone density and increasing risk of fractures.

Alcohol is an addictive drug. Over time, its use can lead to craving, increased tolerance, and impaired control. As this occurs, medical complications increase, as individuals must access treatment both for the associated medical conditions and their underlying cause.

Alcoholism as a Chronic Disease

A chronic disease is one that continues over a long time, progressing either consistently or intermittently. It often can be managed, and is likely to worsen without treatment. The causes of chronic disease can be complex, triggered in different ways, and include hereditary factors. The course of chronic diseases may be unpredictable. Treatment may require that patients change their behavior, and some patients may relapse more frequently than others.

This description closely fits alcoholism. It also describes other chronic diseases such as asthma, diabetes, and high blood pressure.

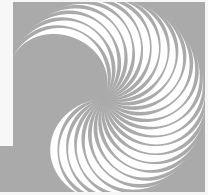
The resemblances among these chronic diseases are striking. Genetics play a heavy role in each, causing individuals to become vulnerable. In the case of alcoholism, studies suggest that genetic factors account for 50-60% of the propensity toward the disease. People who are at genetic risk for asthma, diabetes, high blood pressure, and alcoholism can control certain risk factors. Doing so in the case of alcoholism by choosing not to drink may be more difficult than for other diseases, especially among young people, as social encouragement to use alcohol is widespread. Over time, there is strong evidence that drinking by alcoholics negatively impacts brain chemistry, making it increasingly difficult for individuals to control their disease.

Like asthma, diabetes, and high blood pressure, there is no known cure for alcoholism, but there are clear diagnostic criteria, research-based treatment guidelines and protocols, and proven effective patient and family educational interventions. Following treatment, a higher percentage of patients with alcoholism follow treatment regimens faithfully than do those with other chronic diseases. Relapse rates for alcoholism are no higher, and in some cases, lower than for other chronic diseases.

Four Steps Toward Dealing with Alcoholism as a Chronic Disease

1. Prevention

The most effective public health approach to chronic diseases is to prevent them before they make their appearance. With the aid of the Division of Alcohol and Substance Abuse (DASA) and the Western Center for the Application of Prevention Technology, schools and community coalitions across Washington are applying evidenced-based practices to the prevention of alcohol abuse and alcoholism among youth. These range from *universal* prevention approaches





aimed at entire populations – whether in schools or communities, to *selective* prevention targeting those who are at high-risk for alcohol abuse, to *indicated* approaches aimed at those for whom abuse has already started.

In Washington State, the prevention field makes use of the risk-and-protective framework pioneered by University of Washington researchers Drs. David Hawkins and Richard Catalano. By isolating those factors that put young people at particular risk for substance abuse, and those factors that are protective, the framework enables schools and communities to develop a chain of inference in choosing prevention applications likely to result in reduced levels of alcohol use.

Other factors affecting youth use of alcohol and the long-term progression to alcoholism include price, availability, and advertising, which makes drinking appear glamorous and appealing. New approaches to youth alcohol consumption, such as social marketing, which has been pioneered at Western Washington University, show promise in changing the culture of drinking on college and university campuses, weakening the links between early abuse and the progression to a chronic disease condition.

2. Brief Interventions

As the progression from alcohol abuse to the chronic disease of alcoholism may be slow, individuals may not be fully aware of their symptoms. It is sometimes possible to intervene opportunistically in the life of the alcohol abuser and engage awareness of the need to limit consumption or eliminate it all together, without the need for substance abuse treatment.

Dr. Larry Gentilello conducted a study of patients admitted to the trauma center at Harborview Medical Center. Of 2,524 patients screened, 1,153 (46%) were found to have signs indicative of an alcohol-related problem. Patients

were assigned to two groups: those receiving no follow-up for their alcohol-related problem, and those who received a single motivational interview with a psychologist trained in the use of brief interventions. A focus was placed on the patient's assuming personal responsibility for reducing drinking to decrease his or her level of risk. A menu of strategies was provided, including a list of treatment resources and self-help groups in the community. At the 12-month follow-up, those who received the intervention decreased alcohol consumption by an average of 21.8 alcoholic drinks per week. At the three-year follow-up, they experienced a 47% reduction in injuries requiring emergency department or trauma center admission, and a 48% reduction in injuries requiring hospital admission.⁸

In 2003, the Department of Social and Health Services, Division of Alcohol and Substance Abuse (DASA) received a \$16.1 million 5-year grant from the federal Substance Abuse and Mental Health Services (SAMHSA), Center for Substance Abuse Treatment (CSAT) to implement the Washington State Screening, Brief Intervention, and Referral to Treatment (WASBIRT) program. As a result of the grant, chemical dependency professionals (CDPs) are now working in hospital emergency rooms in Seattle, Tacoma, Everett, Yakima, and Vancouver to screen and refer patients to treatment. WASBIRT is expected to provide services to 184,620 people during the period of the grant at Harborview Medical Center, Tacoma General Hospital, Providence Everett Medical Center, Southwest Washington Medical Center, Yakima Regional Medical Center, and Toppenish Community Hospital.

Similar opportunities for brief interventions exist in regular visits to doctors' offices. It is estimated, however, that fewer than 30% of primary care physicians screen their patients for health problems related to their use of alcohol. Opportunities for brief interventions also exist in the workplace, especially through the use of Employee Assistance Programs.



3. Reducing Stigma

“Changing the Conversation”, the federal Center of Substance Abuse Treatment’s “National Treatment Plan Initiative”, singled out stigma as a powerful, shame-based mark of disgrace and reproach that impedes treatment and recovery. Stigma prevents widespread recognition of alcoholism as a chronic disease. Because of the stigma attached to it, physicians, insurance companies, and even state governments fail to acknowledge alcoholism as a medical problem. Stigma often prevents individuals from seeking care for their addiction.

It should be noticed that the stigma attached to alcoholism has some subtle differences from that attached to drug addiction. Society often views drug addiction as first and foremost a criminal justice problem, and hence those addicted are viewed as criminals, thus hampering both assessment of, and treatment for the condition. In contrast, alcohol use is legal, widespread, and often socially encouraged. Those afflicted with a chronic disease related to its use may be ostracized as “weak-willed” or “lacking in self-control”.

Changing the Conversation proposes a four-step approach to reduce stigma and change attitudes about people at risk for, in need of treatment for, or in recovery from alcoholism (and drug addiction):

- Conduct science-based marketing research (i.e., polling surveys, focus groups) to provide the basis for a social marketing plan;
- Based on the results of the research, implement a social marketing plan designed to change knowledge, attitudes, beliefs, and behavior of individuals and institutions to reduce stigma and its negative consequences;

- Facilitate and support grassroots efforts to build the capacity of the recovery community to participate in the public dialogue about addiction, treatment, and recovery;
- Promote the reduction of stigma and discrimination against people in treatment or in recovery by encouraging respect for their rights in a manner similar to that afforded to people who suffer from and overcome other chronic diseases.

4. Increasing Availability of Treatment

There is a huge gap between those who both qualify for treatment for alcoholism and are in need of it and those who actually receive it. Alcoholism among those with private health insurance that would cover treatment often goes untreated, as more than two-thirds of physicians do not offer appropriate screening and referral. Because of stigma, individuals may deny that they suffer from this debilitating disease, or refuse to seek treatment. Individuals may be reluctant to use Employee Assistance Programs or, in some cases, even their health insurance, for fear that confidentiality may be compromised.

Alcohol is consistently cited as the primary drug of abuse in a large plurality (47%) of adult admissions to DASA-funded treatment. But the treatment gap is such that some 79.2% of adults in need of, and who qualify for DASA-funded treatment (for all drugs, including alcohol) do not receive it. Such levels of unmet need in dealing with any other chronic disease condition would likely be considered medical malpractice.



As treatment providers become increasingly effective in retaining patients until they complete their treatment plans, the number of admissions to publicly funded treatment is likely to decline. DASA-funded admissions to treatment for alcoholism reached their peak in SFY 1999 (17,516) and have been declining steadily since (to 14,186 in SFY 2003). Waiting lists for treatment under the Alcohol and Drug Abuse

Treatment and Support Act have quadrupled since 1991, and have accelerated greatly in the past four years. A new commitment to the funding of quality alcoholism treatment services will be necessary if Washington State is to realize the promise of our ability to turn the tide against the chronic disease that afflicts so many of our citizens.

¹ National Institute on Alcohol Abuse and Alcoholism, *Per Capita Ethanol Consumption for States, Census Regions, and the United States, 1970-1999*.

² National Institute on Alcohol Abuse and Alcoholism, *10th Special Report to Congress on Alcohol and Health*. Washington, DC: Department of Health and Human Services, 2000.

³ U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 26-4. Washington, DC: 2000.

⁴ Mangione, T., Howland, J., and Lee, M., *New Perspectives for Worksite Alcohol Strategies: Results from a Corporate Drinking Study*. Washington, DC: National Institute on Alcohol Abuse and Alcoholism, 1998.

⁵ Center for Substance Abuse Prevention, "Underage Drinking and Academic Performance," *Prevention Alert*, Vol. 5 No. 12, September 27, 2002.

⁶ Foster, S. et. al., "Alcohol Consumption and Expenditures for Underage Drinking and Adult Excessive Drinking," *Journal of the American Medical Association*, 289 (8), February 26, 2003.

⁷ Grant, B. , et al., *2001-2002 National Epidemiological Survey on Alcohol and Related Conditions*. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism, 2004.

⁸ Gentilello, L., et al., "Alcohol Interventions in a Trauma Center as a Means of Reducing the Risk of Injury Recurrence," *Annals of Surgery* 230 (4), July 1999.

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Brief Interventions in Emergency Department and Health Care Settings

Traumatic injury inflicts enormous medical and psychosocial harm on its victims. The greatest underlying cause of injury is the misuse of alcohol and drugs.¹ By intervening in the substance abuse of individuals who frequent emergency departments, alcohol/drug abuse can be reduced, as can injuries requiring emergency department admissions.

Substantial numbers of individuals who visit hospital emergency departments (EDs) present with a diagnosis or injury caused by substance use or abuse disorders. A 2004 study found that nationally between 1992 and 2000, there was an average of 7.6 million ED visits per year for alcohol alone, or 7.9% of all such visits. This is approximately three times higher than previously estimated, based on physician documentation or patient disclosure of alcohol involvement.² It has been estimated that 20-50% of primary care patients may abuse alcohol or drugs and go undetected by their provider.

A wide range of effective treatments has been developed for mild, moderate, and severe drug and alcohol problems. Prior studies have shown that interventions, when delivered to injured patients in hospital EDs and in the inpatient units of hospitals, can reduce alcohol and drug consumption, prevent re-injury, and help patients with more severe problems access intensive, community-based chemical dependency treatment. These services demonstrate that counseling and referral helps reduce adverse health outcomes, reduces cost for medical care, reduces future emergency room use, reduces criminal justice involvement, and improves employment outcomes.

A study conducted at the trauma center at Harborview Hospital in Seattle found that of 2,524 patients screened, 1,153 or 46% tested positive for alcohol abuse. Patients were then randomized either to a control group, or to receive a brief onsite intervention related to the patients' drinking, including information about the risks of alcohol abuse and the availability of treatment resources. At the 12-month fol-

lowup, the intervention group had decreased alcohol consumption by an average of 21.8 drinks per week. At the three-year followup, there had been a 47% reduction in injuries requiring either emergency department or trauma center admission, and a 48% reduction in injuries requiring hospital admission.³

Besides reducing injuries and future ED admissions, early identification of alcohol and drug problems and brief intervention is, in some instances, an effective and cost-saving alternative to more intensive chemical dependency treatment. Early identification of alcohol and drug problems holds out the hope of preventing the progression of chronic substance abuse dependence.

Washington State Screening, Brief Intervention, and Referral to Treatment (WASBIRT)

In 2003, the Department of Social and Health Services, Division of Alcohol and Substance Abuse (DASA) received a \$16.1 million, 5-year grant from the federal Substance Abuse and Mental Health Services (SAMHSA), Center For Substance Abuse Treatment (CSAT) to implement the Washington State Screening, Brief Intervention, and Referral to Treatment (WASBIRT) program.

The goals of WASBIRT are to:

- Provide substance abuse screening in three EDs in two Washington State communities, thereby identifying a large number of patients who have substance abuse problems of all severity levels;
- Deliver brief interventions in EDs to patients admitted to the hospital who are not dependent, but whose misuse places them at increased risk for future re-injury or hospitalization;

- Provide brief treatment (5-12 sessions) on an outpatient basis to some patients who need and want more intensive, brief preventive treatment;
- Increase the number of referrals made to community-based chemical dependency treatment for patients dependent on alcohol and other drugs;
- Reduce subsequent ED utilization, medical costs, criminal behavior, disability, and death by patients with drug and alcohol problems of all severity level; and,
- Involve a multitude of perspectives to explore systems change to improve existing linkages to these services, and to expand substance abuse services to include early intervention.

As a result of the grant, chemical dependency professionals (CDPs) are now working in hospital emergency rooms in Seattle, Tacoma, Everett, Yakima, and Vancouver to screen and refer patients.

WASBIRT is expected to provide services to 184,620 people during the period of the grant at Harborview Medical Center, Tacoma General Hospital, Providence Everett Medical Center, Southwest Washington Medical Center, Yakima Regional Medical Center, and Toppenish Community Hospital.

“Teachable Moments”

In some ways, EDs and trauma centers are ideal sites in which to provide people who drink or use illicit drugs in harmful or hazardous patterns with a targeted intervention at the time of an adverse event—a situation sometimes referred to as a “teachable moment.” The WASBIRT program extends beyond the brief intervention model by providing timely and appropriate referral to more intensive substance abuse treatment where appropriate.

Prior research has demonstrated this to be an effective approach. A 2001 study showed that of 719 patients provided a direct referral to substance abuse treatment over a one-year period, some 80% made contact with the treatment facility, and 78% were admitted to treatment. The negative consequences associated with an ED visit often serve as prime motivators to move patients toward dealing with their substance abuse problems.

It is anticipated that implementation of screening, brief intervention, and referral will result in better health outcomes for patients, and will benefit participating hospitals and communities impacted by these services. Participating hospitals should experience a decrease in hospital ED admissions and hospital admissions caused by use and abuse of alcohol and other drugs and reduced costs associated with those admissions. Communities should be safer, as fewer injury-related events associated with substance abuse are likely to occur. A 1999 study found that within six months of ED brief interventions for alcohol-related problems among older adolescents, there was a 27% reduction in drinking and driving, an 87% reduction in moving violations, and a 58% reduction in alcohol-related injuries.⁴

Missed Opportunities

While EDs provide an excellent venue for intervening in a patient’s substance abuse, the visit to the ED is often late in the chain of opportunities for such intervention. Multiple studies have demonstrated the efficacy of brief intervention in a variety of settings, most notably primary care offices and health care clinics.⁵

Often, however, those opportunities are missed. A 2000 survey of primary care physicians and patients published by the National Center on Addiction and Substance Abuse at Columbia University found that 94% of primary care physicians misdiagnose or fail to diagnose substance abuse when





presented with early symptoms of alcohol abuse in adult patients. Only 19.2% of physicians felt themselves “very prepared” to diagnose alcoholism, and the percentage was lower for illegal drugs (16.9%). Fewer than a third (32.1%) of primary care physicians screen for substance abuse. Reasons cited for physicians failing to make use of intervention opportunities include: lack of adequate training in medical school or continuing education; lack of knowledge of treatment effectiveness; discomfort discussing substance abuse; time constraints; and patient resistance.⁶ A 2004 study found that, of the 7% of patients admitted to hospitals who had indications of alcohol disorders, fewer than half were so diagnosed in their hospital records.⁷

Future Challenges

DASA will continue to pursue opportunities to expand the WASBIRT model into additional EDs and trauma care centers. At the same time, hospitals, health insurers, and health maintenance organizations would do well to examine the cost offsets associated with providing screening, brief intervention, and treatment services for all individuals who enter

EDs. It is likely that the cost of training physicians and other health care professionals to provide appropriate interventions and referrals would be more than offset by decreased ED and hospital utilization.

There is also a substantial need for improved training of health care providers, both in their initial, residency, and continuing educations, on issues related to substance abuse. County medical associations could play an important role in facilitating the education of health care providers about the impact of brief interventions and the availability of community-based treatment resources.

Perhaps most important are efforts to mitigate the effects of stigma on patients, providers, and health care systems. Once substance abuse prevention and treatment efforts are considered part of larger array of health care services, and regularly provided as appropriate, it is likely that overall health care costs will be significantly reduced, and the health of individuals, families, and communities will be significantly enhanced.

¹ *Alcohol and Other Drug Screening of Hospitalized Trauma Patients*, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, TIP 16, Printed 1995

² Alden, J., Wang, N., & Camargo, C., “U.S. Emergency Department Visits for Alcohol-Related Diseases and Injuries Between 1992 and 2000,” *Archives of Internal Medicine* Vol. 164 No. 5, March 8, 2004.

³ Gentilello, L., et al., “Alcohol Interventions in a Trauma Center as a Means of Reducing the Risk of Injury Recurrence,” *Annals of Surgery* 230(4), October 1999.

⁴ Monti, P., et al., “Brief Intervention for Harm Reduction with Alcohol-Positive Older Adolescents in a Hospital Emergency Department,” *Journal of Consulting and Clinical Psychology* 67(6), 1999.

⁵ Fleming, M., et al., “Brief Physician Advice for Problem Alcohol Drinkers,” *Journal of the American Medical Association* Vol. 277, 1997.

⁶ The National Center on Addiction and Substance Abuse at Columbia University, *Missed Opportunity: The CASA National Survey of Primary Care Physicians and Patients*. New York, NY: 2000.

⁷ Smothers, B., Yahr, H., & Ruhl, C., “Detection of Alcohol Use Disorders in General Hospital Admissions in the United States,” *Archives of Internal Medicine*, 164(7), April 12, 2004.

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Criminal Justice

Substance-abusing offenders are the majority of Washington's prison population. The cost to the state in incarcerating these offenders has increased radically in the past two decades. New criminal justice reforms, including a strong commitment to treatment, hold out the promised of reduced incarceration, recidivism, and greater public health and safety.

The last two decades have witnessed substantial increases in the number of drug-related offense cases in both Washington State and across the nation. Coupled with punitive state and federal sanctions for drug possession, manufacturing, and distribution, these increases have contributed significantly to the problems faced by already overtaxed law enforcement agencies and courts, and overcrowded jails and prisons. Additionally, there have been significant increases in the number of substance-abusing offenders serving time for non-drug-related offenses.

Since the July 1, 1984, implementation of the Sentencing Reform Act of 1981 (SRA), the Washington State Legislature has amended adult felony sentencing law in every legislative session except 1985. From State Fiscal Year 1985-2003, the number of drug offenders in state prisons increased well over 1,700%, from 173 to 3,253. Of the 16,520 offenders in state prisons at the end of SFY 2003, 19.7% were drug offenders (compared to 2.6% at the end of SFY 1985).

While drug offenders make up an ever-increasing percentage of the state's prison population, they are not the only offenders in need of substance abuse treatment. The Department of Corrections (DOC) estimates that 60-80% of inmates are in need of substance abuse treatment. Only a fraction receive treatment.

Without appropriate treatment, substance-abusing offenders, once released, are more likely to re-offend and, therefore, will be returned to prison. The operational costs of incarcerating these offenders, and the costs of servicing the

debt associated with the capital expansion needed to create beds for the continually increasing inmate population, are overwhelming. The operational costs alone of incarcerating drug offenders has increased from \$3.0 million in SFY 1985 to \$89.1 million in SFY 2003 – an increase of over 3,000% since the implementation of the SRA. This does not include operational costs for other substance-abusing offenders; nor does it include any capital expenditures.

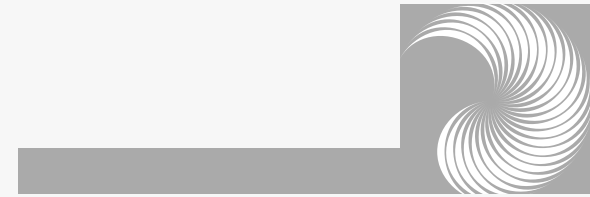
Additionally, none of the above takes into account the costs to victims, or to law enforcement, courts, and local jails in dealing with substance-abusing offenders. Adult and juvenile arrests for drug offenses alone increased from 17,248 in 1993, to 27,925 in 2003, representing a 62.2% increase.

It has become increasingly clear to criminal justice personnel and policymakers that the traditional means of adjudicating and punishing non-violent drug-abusing offenders, while expensive, has not worked effectively. It has done little to reduce criminal recidivism, curtail drug use, or enhance public safety.

The Effectiveness of Treatment

As the cost of incarcerating offenders has risen, there has been a growing awareness of the effectiveness of substance abuse treatment in reducing recidivism and costs. A 2002 study of patients receiving publicly funded treatment in Washington State examined arrest records before and after treatment. The study found:

- A 21% decline in the number of patients arrested following treatment;
- A 33% decline in the number of arrests for felony offenses following treatment; and
- Reduced risk of felony arrests for patients that complete treatment and for those with longer stays.¹



A review of all drug court evaluation studies in the United States undertaken by the Washington Institute for Public Policy concluded that drug courts save nearly three dollars for every dollar of taxpayer expenditure when factoring in victim costs, and they reduce recidivism (compared to standard courts) from 45.8% to 39.7%, representing a decrease of 13.3%.² Providing treatment to substance-abusing offenders benefits offenders, the criminal justice system, taxpayers, and communities.

Drug Courts

The strategy behind drug courts is to use the coercive power of the criminal justice system to force substance abusing offenders to undergo chemical dependency treatment. By treating substance abuse problems, criminal recidivism and the associated criminal justice costs, as well as the greater social and economic costs associated with substance abuse, can be reduced.

The first drug courts began operation in Washington State in 1994. As of July 2004, there are adult drug courts in the following communities:

Counties:

Benton-Franklin	Kitsap	Snohomish
Clallam	Kittitas	Spokane
Clark	Lewis	Thurston
Cowlitz	Mason	Whatcom
Jefferson	Pierce	Yakima
King	Skagit	

Federally Recognized Tribes:

Lummi
Makah
Spokane
Yakima Indian Nation

In addition to adult and tribal drug courts, there are juvenile, youth-at-risk, misdemeanor, dependency and family treatment courts, all using the drug court model. King County operates a mental health court that utilizes the drug court model to serve mentally ill offenders. Overall, Washington has 30 operating non-tribal and tribal drug courts, two mental health courts, and 14 drug courts in the planning stages. Additionally, drug courts will be a primary mechanism for providing judicially supervised treatment under the new criminal justice reform measures.

Adult Offenders

Drug Offender Sentencing Reform

With bipartisan support, Second Substitute House Bill 2338 was passed by the 2002 Legislature and signed into law by Governor Locke. The law effects major changes in drug offender sentencing in Washington State. Key provisions of the new law include:

- Establishing the Criminal Justice Treatment Account (CJTA), funded out of savings to the Department of Corrections by reducing sentences for certain drug offenders;
- Utilizing savings for treatment and limited treatment support services;
- Establishing work groups to develop a methodology for calculating the savings; formulas and grant processes for distributing the funds to the counties; and county plans for submission to the formula and grant panels;
- Establishing a drug offender sentencing grid and a review committee;
- Setting minimum standards for the participation of offenders in drug courts; and



- Authorizing studies of the effectiveness of the new sentencing grid and drug courts.

Under the new statute, resultant prison bed savings are to be calculated for each biennium. Beginning July 1, 2005, \$8,250,000 per fiscal year will be transferred from the General Fund to the CJTA. The money transferred to the CJTA will be distributed by the Division of Alcohol and Substance Abuse to counties (70% using a funding formula, and 30% through a grant program) for use in providing substance abuse treatment for offenders at the local level. Additional funds will be transferred to the Department of Corrections for the purpose of substance abuse treatment services for offenders confined to state prisons. Some 5,500 offenders are expected to receive treatment during the 2005-2007 Biennium as a result of CJTA.

Since the statute became effective, continuous progress has been made toward implementation of its provisions. All of the work groups and committees established by the bill have been formed and have been working toward their assigned goals. The work group charged with developing a methodology for calculating the biennial savings under the bill has completed that task, as demonstrated by the estimated savings shown above. The CJTA Panel has established a formula – utilizing combination of the percentage of at-risk adults (age 18 to 54) in each county at or below 200% of the Federal Poverty Line, the number of certain felony and misdemeanor filings in each county, and the percentage of adults in each county at or below 200% of the Federal Poverty Line who are in need of treatment – to distribute 70% of the CJTA funds. The Panel has also established criteria for distributing the other 30% of the money via grants, and is currently in the process of reviewing the grant applications to determine which counties will receive grant funds.

Drug Offender Sentencing Alternative

The Drug Offender Sentencing Alternative (DOSA) is an adult felony sentencing alternative aimed at providing substance abuse treatment for certain offenders. An offender is eligible for DOSA if:

- (s)he is convicted of a felony that carries a standard range of more than one year;
- the felony is not a sex offense or a violent offense and does not involve a weapon enhancement;
- the offender has no prior convictions for a sex offense or a violent offense, and is not subject to a deportation detainer or order; and
- if the offense is a drug offense, the quantity of the drug involved is small.

If an eligible offender is sentenced under DOSA, the offender receives a prison term that is one-half of the midpoint of the standard sentence range in length, community custody for the remainder, and must meet various other conditions. While the offender is serving the term of confinement, (s)he undergoes a comprehensive substance abuse assessment and receives appropriate treatment. Some 3,012 offenders received chemical dependency treatment under DOSA in SFY 2002.

Department of Corrections

While offenders sentenced under DOSA are given priority for substance abuse treatment services in DOC, they are not the only offenders who receive treatment. Any offender under the supervision of DOC assessed as having substance abuse problems may be eligible for treatment. Substance abuse treatment services are provided to about 6,000 offenders annually, at 33 locations throughout the state. Services



offered include long-term residential (in the form of modified therapeutic communities), intensive outpatient, and standard outpatient treatment. Additionally, specialized dual-diagnosis, maintenance, and gender-specific treatment tracks are being developed. Offenders in correctional facilities or under supervision in the community are both eligible for treatment.

City and County Jails

Many of the local jails in Washington State provide some form of substance abuse treatment for incarcerated offenders. Based upon a 1999 survey of the 37 county jails and 20 city jails operating: 13 county jails offered drug and alcohol education or awareness, 16 county jails and three city jails provided for non-medical detoxification, 35 county jails and seven city jails offered substance abuse self-help group programs, and 12 county jails provided additional substance abuse treatment.³

Juvenile Offenders

Juvenile Rehabilitation Administration

The Juvenile Rehabilitation Administration (JRA) estimates that 75.3% of youth entering its facilities have substance abuse-related problems.⁴ JRA has adopted an integrated service model to develop and implement substance abuse programming, with a primary goal of reducing recidivism through the early identification and treatment of chemical abuse. Among the substance abuse services provided by JRA are: screening, assessment, and diagnosis; substance abuse education; inpatient and intensive outpatient treatment at several facilities, recovery house services at one facility; and transitional and aftercare treatment services. Approximately 96 youths are served each month.

Chemical Dependency Disposition Alternative

The Chemical Dependency Disposition Alternative (CDDA) provides juvenile courts with a sentencing option for substance-abusing juvenile offenders, allowing judges to order youth into treatment instead of confinement. A juvenile is eligible for CDDA if (s)he has committed a specific type of offense subject to a standard range disposition of local sanctions or 15-36 weeks of confinement, and has a substance abuse problem. Under CDDA, the court imposes the standard range sentence or raises it, suspends the disposition, places the offender on community supervision for up to one year, orders outpatient and/or inpatient substance abuse treatment, and may impose up to 30 days of confinement, 150 hours of community restitution, and payment of legal financial obligations and restitution.

CDDA represents a collaboration between the Juvenile Rehabilitation Administration (JRA), Medical Assistance Administration, DASA, local juvenile courts, the University of Washington and county alcohol/drug coordinators. According to JRA, 568 juveniles received chemical dependency treatment under CDDA in SFY 2003.

Local Juvenile Detention Facilities

Most local juvenile detention facilities in Washington State offer some form of substance abuse treatment. Based upon a 1999 survey of local juvenile detention facilities in Washington State, 19 of the 21 operating facilities offered substance abuse treatment: 11 offered substance abuse treatment under the CDDA program; 17 offered substance abuse self-help group programs; nine facilities had non-CDDA certified outpatient treatment; and 12 facilities provided additional forms of substance abuse.⁵

¹ Washington State Department of Social and Health Services, Research & Data Analysis Division. *Fact Sheet 4.42*. Olympia, WA: March 2002.

² Washington State Institute for Public Policy, *Washington State's Drug Courts for Adult Defendants: Outcome Evaluation and Cost-Benefit Analysis*. Olympia, WA: March 2003.

³ Vukich, E. and Daniels, K., *City and County Jails in the State of Washington: The Washington State Master Capacity Plan Snapshot Report*. Olympia, WA: Washington Association of Sheriffs and Police Chiefs, Washington State Department of Corrections, Washington State Sentencing Guidelines Commission, 2000.

⁴ Client Tracking System, Juvenile Rehabilitation Administration, Washington State Department of Social and Health Services, May 2004.

⁵ Vukich, E., *Juvenile Detention in Washington State: Population, Capacity and Programming in Local Facilities*. Olympia, WA: Washington State Sentencing Guidelines Commission, 2000.

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Opiate substitution treatment is scientifically proven to be effective in the treatment of heroin addiction, resulting in reductions in criminal behavior, lower medical and psychiatric costs, improved health, and lower rates of illicit drug use. A new medication for opioid maintenance, buprenorphine, can be dispensed by physicians in their offices, and shows promise as another treatment option.

In 2000, approximately 1.2% of U.S. residents ages 12 and over reported heroin use at least once in their lifetime, with approximately 104,000 new heroin users in 1999.¹ The White House Office of National Drug Control Policy estimates there may be as many as 980,000 users of heroin nationwide.² It is estimated that in 2000 approximately 30,665 Washington State adult residents were in need of treatment for heroin addiction.³ Most do not receive treatment. The National Institutes of Health estimate the financial costs of untreated heroin addiction to individuals, families, and society in the U.S. at approximately \$20 billion each year.⁴

People with chronic heroin addiction pose a significant public health risk to our communities. As a large majority are injection drug users (IDUs), heroin addicts are more likely to contract and spread HIV and hepatitis B and C. The federal Centers for Disease Control and Prevention estimate that IDUs (most of whom are heroin users), their sexual partners, and their offspring account for approximately 35% of new HIV infections each year.⁵ Chronic heroin users are more likely to engage in criminal activity, and are more likely to place increased strain upon public resources in welfare costs, emergency room and hospital admissions, and psychiatric hospitalizations.

Scientifically Proven

Methadone and other forms of opiate substitution have been shown scientifically to work effectively in the treat-

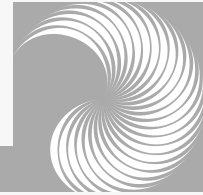
ment of heroin addiction. In its 2000 National Drug Control Strategy, the White House Office of National Drug Control Policy called methadone therapy "one of the longest established, most thoroughly evaluated forms of drug treatment."⁶ A Consensus Panel convened by the National Institutes of Health (NIH) in 1997 concluded, "Methadone treatment significantly lowers illicit opiate drug use, reduces illness and death from drug use, reduces crime, and enhances social productivity." A 1998 review by the General Accounting Office found that methadone therapy helps keep more than 179,000 addicts off heroin, off welfare, and on the tax rolls as law abiding, productive citizens.⁷

Seattle-King County – An Instructive Story

The experience of Seattle-King County is particularly instructive. In King County, it is estimated that there are between 15,000-20,000 injection drug users, 70% of whom are chronic heroin users and could benefit from treatment. From 1990 to 1998, the rate of heroin-related deaths in King County grew more than 170%. In 1998, there were more unintentional opiate overdose deaths in King County (143) than traffic deaths (119).⁷

Faced with an epidemic, city and county government undertook a coordinated response to address heroin addiction. King County authorized a 50% expansion in the number of opiate substitution treatment slots, and authorized a mobile methadone clinic. The County also provided preventive and limited substance-abuse treatment services in the local criminal justice system, and expanded the availability of drug-free housing for individuals in recovery.

One result was that heroin-related deaths in King County declined dramatically, by 57% to 61 in 2001. The rate of heroin-related deaths fell from 8.8 per 100,000 people in 1998 to 3.5 per 100,000 in 2001. Emergency room mentions of heroin similarly declined, from 78 per 100,000 people in



July-December 1997, to 38 in January-June 2001, representing a 51% decrease.

More recently, however, new treatment admissions have also declined, probably because effective treatment is resulting in longer treatment stays, and correspondingly fewer open treatment slots.⁸ There is now a waiting list of almost 700 people in King County at the Seattle Needle Exchange who have requested treatment (compared with fewer than 200 in 1997), but are unable to access it because of limited treatment capacity and sources of funding. Waiting time can be as long as two years or longer.⁸ The result is that, between 2001-2002, the number of heroin-related deaths rose from 61 to 87, representing a 42.6% increase.

The Situation in Washington State Today

Opiate substitution treatment clinics have been operating in Washington State for almost 30 years. As of August 2004, there are 16 opiate substitution treatment clinics operating in five counties. Six fixed locations and one mobile clinic are in King County, two of which serve only private-pay patients. Pierce County has two clinics (now operating as a single program), and Spokane, Yakima, and Thurston Counties each have one. There are two clinics in Snohomish County, one operated by the Stillaguamish Tribe. Clark County contracts with an opiate substitution treatment program in Portland, Oregon to serve its residents. The Veterans Administration contracts with two clinics (in Spokane and Yakima) to provide services, and, additionally, operates two clinics itself in the Puget Sound region.

As of January 1, 2003, 3,317 individuals were receiving opiate substitution treatment for heroin addiction, an increase of 1.3% over the same date in 2002. Of these, 1,703 (51.3%) were publicly funded.

Patient Profile

RCW 70.96A.420(4) requires DASA to provide an “outcome analysis” of programs providing opiate substitution treatment. In fact, DASA has been studying opiate substitution treatment for almost a decade and has established appropriate performance measures for evaluating cost effectiveness and efficacy.

The 2004 Report to the Legislature, *Determining the Value of Opiate Substitution Treatment* profiled patients receiving treatment on January 1, 2003. Among publicly funded patients, 54% were female, and 78% were white (non-Hispanic). Median age was 42 (with a range of 17-76), with 46% having children under age 18. Some 89% of publicly funded patients reported heroin as their primary substance of abuse, but all but 2% were also abusing other substances upon entry into treatment. Median age of first use was 16 (with the youngest being age 10), indicating that the average methadone patient had been using heroin for 26 years prior to current entry into treatment. Other studies indicate that most patients are likely to have had multiple prior entries into drug-free treatment for their addiction.

Treatment Works

A study was undertaken, as part of the Washington State Outcomes Project under the direction of Dr. Molly Carney, Alcohol and Drug Abuse Institute, University of Washington, of those admitted to opiate substitution treatment. The study was designed to evaluate the effectiveness of opiate substitution treatment. Some 135 adults admitted to publicly funded treatment at two Seattle-based methadone programs participated, with interviews administered at admission, and 6- and 12-months post admission.⁹

Some 11.9% of patients reported that their admission to opiate substitution treatment was prompted by the criminal justice system; 18.5% reported they were on or probably on



parole at time of admission. Legal pressure had no significant impact on patient length-of-stay (the average for those with legal pressure was 216.1 days; without legal pressure 242.3 days).

Treatment resulted in significant improvements among patients, at both the 6- and 12-month follow-ups. These included:

- **Increases in number of days employed** – There was a significant improvement in the number of days employed; from 2.4 days in the past 30 days at treatment admission, to 4.5 days in the 30 days prior to the six-month follow-up, and to 5.1 days in the 30 days prior to the 12-month follow-up. Average monthly income from employment rose from \$161 in the month prior to treatment admission, to \$330 in the month prior to the 12-month follow-up for those who remained in treatment.
- **Reductions in number of days engaged in illegal activity** – There was a large decline in the number of days engaged in illegal activity; from 21.1 days in the past 30 days to 2.1 days at the six-month follow-up, and to 2.5 days at the 12-month follow-up. For those who were still enrolled in treatment at the 12-month follow-up, days of illegal activity were reduced to 0.5.
- **Decreases in number of days of heroin use** – Days of heroin use were reduced from 25.0 in the 30 days prior to admission to 6.5 days for the 30 days prior to the six-month follow-up, and 5.4 days for the 30 days prior to the 12-month follow-up. For those who remained in treatment at 12 months, 85.5% were wholly abstinent from heroin.
- **Declines in number of days with medical problems** – Patients reported a small reduction in days of medical problems, from 12.5 days in the 30 days prior to treatment admission, to 11.1 days in the 30 days prior to

the six-month follow-up, and to 9.1 days in the 30 days prior to the 12-month follow-up (representing a 27.2% reduction). Many patients enter methadone treatment with long untreated medical conditions.

- **Reductions in number of days with drug problems** – Opiate substitution resulted in very large reductions in the number of days patients experienced drug problems. Some 65.9% reported a decrease in the number of days with drug problems between admission and the six-month follow-up. Patients reported 24.0 days with drug problems in the 30 days prior to treatment admission. This declined to 9.8 days at 30 days prior to the six-month follow-up, and to 7.2 days in the 30 days prior to the 12-month follow-up. Those still enrolled at 12 months reported only 3.6 days experiencing drug problems in the previous 30 days.

An interesting result of Dr. Carney's study, which has also been seen in other studies, is that it found a relationship between methadone dosing and treatment retention. The study examined two programs, with different mean peak doses: the first with a peak dose of 109.1 mg/day, the second with a peak dose of 83.1 mg/day. In the first program, average length of stay was 284.2 days, almost 50% greater than in the second, at 193.5 days. At 180 days following admission, 80.9% of participants in the first program were retained, while in the second, less than half (47.8%) remained. More research is needed to establish best practices in dosing levels specific to patients now being treated in Washington State clinics.

Challenges Ahead

Better treatment outcomes for opiate substitution patients are clearly tied to longer treatment retention. This poses a special challenge for providers and for the Division of Alcohol and Substance Abuse, as efforts to retain patients in



treatment longer mean that fewer patients are able to access treatment at all. Without increased capacity and funding, waiting lists continue to get longer. Not being able to provide treatment in a timely fashion to those who request it means a continuation of crime and criminal justice costs, higher emergency room and hospital admissions, and continued HIV and hepatitis B and C disease spread.

The King County Bar Association's (KCBA) Drug Policy Project is now spearheading advocacy efforts to expand the availability of opiate substitution treatment to all low-income, Medicaid-eligible individuals in the County. It is estimated that there are more than 700 such individuals in King County, and that providing methadone treatment for all of them would cost approximately \$2.56 million per year, half of which would be federal funds. KCBA is coordinating its efforts with a range of partners, including the King County Medical Society, Washington State Medical Association, Washington State Pharmacy Association, Seattle League of Women Voters, and Municipal League of King County. Representatives of the Drug Policy Project have been meet-

ing with the Governor's Office and key legislators and legislative staff to promote wider opiate substitution treatment access.

A second approach is to find ways to reduce demand for methadone maintenance treatment by intervening in the lives of patients before addiction has already become chronic and such treatment is needed. A new medication, buprenorphine, has been approved for dispensing through physician offices, once physicians have received the necessary training. Buprenorphine has shown effectiveness in studies conducted in other countries, provided appropriate counseling is also available as part of the treatment regimen. As of July 2004, the federal Substance Abuse and Mental Health System Administration reported that 35 Washington State physicians are now authorized to prescribe buprenorphine to opiate-addicted patients. The number of patients each physician can treat with buprenorphine is 30. It is reported anecdotally that the vast majority of patients being treated with buprenorphine have private health insurance coverage.

¹ Office of Applied Studies, *Summary of Findings from the 2000 National Household Survey on Drug Abuse*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001.

² Office of National Drug Control Policy, *National Drug Control Strategy: 2000 Annual Report*, 16. Washington, DC: Office of the White House, 2000.

³ This number was ascertained by taking the state adult population for 2000 and multiplying it by .007 (.7%), the percentage derived by the Department of Social and Health Services utilizing data from the National Household Survey on Drug Abuse.

⁴ National Institutes of Health, *Effective Medical Treatment of Heroin Addiction: NIH Consensus Statement 1997*, November 17-19, 1997.

⁵ Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report*. Atlanta, GA: U.S. Department of Social and Health Services, Public Health Service, 1998.

⁶ Office of National Drug Control Policy, *National Drug Control Strategy: 2000 Annual Report*, 57. Washington, DC: Office of the White House, 2000.

⁷ Ibid.

⁸ Solet, D., Hagan, H., Nakagawara, J., Plough, A., and Ball, J. "Unintentional Opiate Overdose Deaths - King County, 1990-1999. *Morbidity and Mortality Weekly*, 49:29, pp. 636-640.

⁹ Banta-Green, C., et al. "Recent Drug Abuse Trends in the Seattle-King County Area", *Epidemiologic Trends in Drug Abuse*, June 2002.

¹⁰ Personal Communication, Dr. Michael Hanrahan, Seattle-King County Department of Public Health, June 2000.

¹¹ Carney, M., et al. *Washington State Outcomes Project: Opiate Study Sample - Final Report*. Olympia, W: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2003.

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Recognition of the close links between substance abuse and child abuse and neglect is growing. Yet, access to chemical dependency treatment for parents with children in the child welfare system remains difficult. The Division of Alcohol and Substance Abuse is now working with the Children's Administration to foster greater understanding and improve collaboration between the substance abuse prevention and treatment and child welfare systems.

Child Maltreatment 2002, a report issued by the U. S. Department of Health and Human Services, Administration for Children & Families, Children's Bureau, indicates there were an estimated 896,000 confirmed victims of child abuse or neglect in 2002, a rate of 12.3 per 1,000 in children in the national population. More than 60% experienced neglect; 20% were physically abused; 10% sexually abused; and 7% emotionally maltreated. An estimated 1,400 fatalities were attributed to child abuse and neglect, 76% of them children younger than four.¹ Every day hundreds of thousands of young people suffer the effects of family dysfunction, violence, homelessness, crime, and poverty that result from living in a household impacted by substance abuse. Experts agree there is a strong, frequently occurring correlation between parental chemical dependency and child abuse and neglect.

A 1999 report from the National Center on Addiction and Substance Abuse at Columbia University found that parental substance abuse causes or exacerbates seven out of ten cases of child abuse and neglect, and results in \$20 billion annually in federal, state, and local government spending. Children whose parents abuse drugs or alcohol are three times more likely to be abused and four times more likely to be neglected than are children of parents who are not substance abusers.²

In Washington State, the federal 2004 Child and Family Services Review found that substance abuse is the primary

Substance Abuse and Child Welfare

reason for opening 10% of the child welfare cases reviewed. Substance abuse was cited in 34% of the cases as the reason for children coming to the attention of the Washington Child Protective Services.³

Two Different Systems

The child protective services system and substance abuse prevention and treatment field operate with different goals, philosophies, and mandates. The highest priority of the child welfare system is to provide immediate protection for children, often beginning by removing the child from immediate risk of harm. Secondary goals are to move children into a stable environment as quickly as possible, and then, once the risk in the original home is eliminated, to attempt family reunification. Chemical dependency treatment, in contrast, is directed at assisting clients in controlling a chronic disease condition and helping them move through what is often a slow process of recovery.

Furthermore, accessing chemical dependency treatment in a timely manner remains difficult. Nationally, 67% of the parents with children in the child welfare system require chemical dependency treatment, but the child welfare agencies are able to ensure treatment for only 31% of them. Complicating matters still further is the difficulty in getting child welfare workers, already burdened by large caseloads, to document the impact of parental substance abuse on parenting and family functioning, for which they are not fully trained.

The 2004 Child and Family Services Review final report determined that there is a critical gap in service array in Washington State, particularly in the areas of mental health and substance abuse treatment. In addition, while research has shown that consistent exposure to parental abuse of alcohol and other drugs may contribute to the development of a child's own substance abuse problems, there is often a

critical lack of targeted developmentally appropriate substance abuse prevention services for children of chemically dependent parents. In short, there is much work yet to be done.

Future Directions

Staff from both systems should be provided with opportunities to learn about the other system. Training should include content on the interrelatedness of substance abuse and forms of family violence, such as child abuse and neglect. The substance abuse treatment workers need to have a better understanding of the child welfare system and the importance of family dynamics in support of reunification. In addition, child welfare workers need to have a better understanding of addiction and the recovery process. It is also important to increase interagency communication and collaboration between the two systems, working together with the client's best interest in mind. Case conferences should include all of the individuals who are working with the family. This includes sharing information and concerns about the clients.

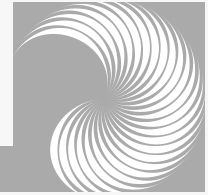
The costs of parental alcohol and other drug use are incalculable and the scars of drug and alcohol spawned parental abuse and neglect is likely to be permanent. Through increased collaboration, education, and information sharing, both the child welfare system and chemical dependency system will be better able to serve the families impacted by substance abuse.

Recognizing common challenges and opportunities, in July 2004, the Washington State Division of Alcohol and Substance Abuse and the Children's Administration have drafted an interagency agreement to improve access to and use of chemical dependency treatment services for families, and prevention services for youth. Included in the agreement are commitments to develop a comprehensive and collaborative training plan to foster greater understanding of alcohol/drug-related issues, earlier identification of substance abuse, and more systematic intervention, including screening and treatment referral.

¹ Children's Bureau, *Children Maltreatment 2002*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, 2004.

² Reid, J., Macchetto, P., and Foster, S., *No Safe Haven: Children of Substance-Abusing Parents*. New York, NY: National Center on Addiction and Substance Abuse at Columbia University, 1999.

³ Children's Bureau, *Child and Family Services Review—Washington State*. Washington, DC: U.S. Department of Health and Human Services Administration for Children and Families Administration on Children and Families Administration on Children, Youth and Families, Children's Bureau, 2004.



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Dependence



The links between tobacco use and chemical dependency are well-established. Smoking significantly increases the risks of death and disability among alcohol- or drug-dependent individuals, and may negatively impact recovery. The Division of Alcohol and Substance Abuse has launched a new initiative to address nicotine dependence within the substance abuse treatment delivery system.

Tobacco use is the leading cause of death and disability in the United States and in Washington State. Since the first U.S. Surgeon General's Report "On Tobacco and Health" in 1959, there have been more than 12 million deaths in the U.S. attributable to smoking. An estimated 8.6 million people in the U.S. have at least one serious illness caused by smoking. Each year, approximately 440,000 people in the United States die of a smoking-attributable illness. Among current smokers, chronic lung diseases account for 73% of smoking-attributable conditions. Excluding adult deaths from exposure to secondhand smoke, adult males lose an average of 13.2 years of life, and adult females 14.5 years of life as a result of smoking.¹

A large majority of current smokers (70%) report that they either want to quit, or have attempted to quit and failed.² While it is likely that some of the difficulty that individuals have in quitting is related to the social experience of smoking, the main reason for the difficulty is that one of the active ingredients in tobacco – nicotine – is a highly addictive drug. Researchers have discovered that nicotine raises the levels of a neurotransmitter called dopamine in the areas of the brain that produce feelings of pleasure and reward. Dopamine is the same neurotransmitter involved in addiction to cocaine and heroin, and researchers now suspect that changes in dopamine levels play a key role in all addictions.³

Historically, tobacco use has been accepted within the substance abuse treatment community. Nationally, more than

Treatment for Nicotine Dependence

80% of individuals addicted to alcohol and/or other drugs smoke cigarettes, compared with 23% of the non-addicted population.⁴ In State Fiscal Year 2003, 73.2% of adults and 58.1% of youth (ages 12 to 17) who received chemical dependency treatment funded through the Division of Alcohol and Substance Abuse (DASA) in Washington State were smokers. Acceptance of tobacco use has been based on the common assumption that individuals receiving chemical dependency treatment should achieve some success in dealing with addiction to their primary substance of abuse before attempting to quit smoking.

However, both the prevalence of tobacco use among those who are chemically dependent and research on the association between the use of nicotine and other drugs suggest that this is not a sound approach:

- Craving for nicotine appears to be linked to increased craving for illicit drugs among drug abusers who also smoke. The more cigarettes smoked, the more likely the individual was to use illicit drugs.⁵
- Compared with the risk for nonsmoking nondrinkers, the relative risk for developing mouth, throat, and esophageal cancer is seven times greater for tobacco users, six times greater for alcohol users, and 38 times greater for those who use both tobacco and alcohol.⁶
- Alcohol- and drug-addicted individuals who receive treatment and who also stop using tobacco products are up to eight times more likely to remain in recovery.⁷

Research indicates that up to 70% of recovering drug- and alcohol-dependent patients may be interested in receiving smoking cessation counseling and treatment. In SFY, 73.9% of adults smokers, and 67.9% of youth smokers (ages 12-17) who entered DASA-funded chemical dependency treatment had previously tried to quit. Clearly, a different approach is



called for, one that makes use of the skills and commitment of experienced chemical dependency treatment professionals in assisting their patients in going smoke-free.⁸ At least one study has shown that efforts to stop smoking are associated with improved chemical dependency treatment outcomes.⁹

New Life Nicotine Dependency Program

In 2002, the Washington State Department of Health (DOH) and DASA launched a new initiative to begin to address nicotine dependence within the substance abuse treatment delivery system. As part of this initiative, DOH and DASA jointly developed the *New Life Nicotine Dependency Program* to promote increased awareness of the importance of addressing smoking during chemical dependency treatment, and to provide technical assistance to treatment programs to help them incorporate nicotine-free policies and interventions for nicotine dependence. In June 2003, DASA began offering free nicotine addiction treatment training to program administrators, counselors, and support staff.

In addition, DASA and DOH, with strong assistance from Tacoma Community College, have inaugurated a Nicotine Policy Advisory Committee (NICPAC) to provide policy and guidance to chemical dependency treatment providers on the integration of nicotine use interventions into treatment. NICPAC advises DASA on training and policy needs; suggests changes in Washington Administrative Code (WAC) and contract language; recommends strategies for working with the Insurance Commissioner and Medicaid to ensure access to treatment for nicotine dependence; provides advice on funding resources that can be used as incentives for providers; and identifies successful programs and models that providers can use to attain success in nicotine-free facilities.

Patients who receive nicotine addiction treatment stand much to gain. A 50-year retrospective study of British physicians who smoke found that nearly all the risk of dying prematurely from smoking can be eliminated if people quit before the age of 30, and half the risk can be eliminated if individuals stop by age 50.¹⁰

¹ U.S. Surgeon General, *The Health Consequences of Tobacco Use*. Atlanta, GA: U.S. Department of Health and Human Services, U.S. Public Health Service, 2004.

² Centers for Disease Control and Prevention, *National Health Interview Surveys*. U.S. Department of Health and Human Services, U.S. Public Health Service, 2002.

³ Epping-Jordan, M., et al., "Dramatic Decreases in Brain Reward Function During Nicotine Withdrawal," *Nature* 393(76), 1998.

⁴ Ordor-Connors, B., "Addressing Tobacco in the Treatment of Other Addictions: The New Jersey Approach," UMDNJ-Tobacco Dependence (www.tobaccoprogram.org), 2004.

⁵ Frosch, D., et al., "Associations Between Tobacco Smoking and Illicit Drug Use Among Methadone-Maintained Opiate-Dependent Individuals," *Experimental and Clinical Psychopharmacology* 8(1), 2000;

Taylor, R., et al., "Tobacco Craving: Intensity-Related Effects of Imagery Scripts in Drug Abusers," *Experimental and Clinical Psychopharmacology* 8(1), 2000.

⁶ National Institute on Alcohol Abuse and Alcoholism, *Alcohol Alert* 39, 1998; Bethesda, MD: U.S. Department of Social and Health Services, National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism.

⁷ Stuyt, E., "Recovery Rates After Treatment for Alcohol/Drug Dependence: Tobacco Users vs. Non-Tobacco Users," *American Journal on Addictions* 6(2), 1997.

⁸ Clemmey, P., et al., "Smoking Habits and Attitudes in a Methadone Maintenance Treatment Population," *Drug and Alcohol Dependence* 44, 1997.

⁹ Sees, K., and Clark, H., "When to Begin Smoking Cessation in Substance Abusers," *Journal of Substance Abuse Treatment* 10, 1993.

¹⁰ Doll, R., et al., "Mortality in Relation to Smoking: 50 Years' Observation on Male British Doctors," *British Medical Journal* 328, June 2004.

Data Sources



DATA SOURCES



Data Sources

Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State – 2004 contains information and data from a wide variety of federal and state government agencies. Given the diverse indicators included in this Report, data sources differ significantly with regard to methodology, sampling and collection procedures, as well as in the reliability and validity of the data. Report users are encouraged to consult the original data sources for more detailed information.

National Sources

Monitoring the Future (MTF) (www.isr.umich.edu/src/mtf)

Conducted by the Institute for Social Research, University of Michigan, and supported by research grants from the National Institute on Drug Abuse, the Monitoring the Future (MTF) project studies changes in the beliefs, attitudes, and behavior of young people in the United States. Surveys have been carried out each year since 1975. Students in the 8th, 10th, and 12th grades complete self-administered, machine-readable questionnaires in their classrooms. Surveys are administered from February to May, invalidating direct comparisons with results from a similar survey – the Washington State Survey of Adolescent Health Behaviors – which is administered in October. Data are used to monitor trends in substance use and abuse among adolescents, and progress toward national education goals for safe, disciplined, and alcohol- and drug-free goals. Results are also used in development of the White House National Drug Control Strategy.

National Institute on Drug Abuse (NIDA) (www.nida.nih.gov/)

The mission of the National Institute on Drug Abuse (NIDA) is to lead the nation in bringing the power of science to bear on drug abuse and addiction. NIDA seeks to accomplish this mission through the strategic support and conduct of research across a broad range of disciplines. NIDA supports over 85% of the world's research on health-related aspects of drug abuse and addiction. NIDA also works to ensure the rapid and effective dissemination and use of results from research to significantly improve drug abuse and addiction prevention, treatment, and policy. NIDA is one of the 19 institutes that comprise the National Institutes of Health (NIH).

National Institute on Alcohol Abuse and Alcoholism (NIAAA) (www.niaaa.nih.gov/)

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) is one of 19 institutes that comprise the National Institutes of Health (NIH), the principal biomedical research agency of the federal government. NIAAA provides leadership in the national effort to reduce alcohol-related problems by:

- Conducting and supporting research in a wide range of scientific areas including genetics, neuroscience, epidemiology, health risks and benefits of alcohol consumption, prevention, and treatment;
- Coordinating and collaborating with other research institutes and federal programs on alcohol-related issues;
- Collaborating with international, national, state, and local institutions, organizations, agencies, and programs engaged in alcohol-related work; and



Data Sources

- Translating and disseminating research findings to health care providers, researchers, policymakers, and the public.

NIAAA-supported research and direction are aimed at:

- Removing the stigma associated with the common complex disease of alcoholism;
- Revealing genetic, other biological, and sociocultural origins of variations in individual responses to alcohol and the consequent risks and benefits of alcohol to health;
- Developing effective prevention and treatments that address the physical, behavioral, and social risks attributable to excessive and underage alcohol consumption, and the chronic relapsing nature of alcoholism; and
- Improve the acceptance of, and access to, quality care.

Bureau of Justice Statistics (BJS) (www.ojp.usdoj.gov/bjs/)

The Bureau of Justice Statistics (BJS), part of the Office of Justice Programs within the U.S. Department of Justice, is the nation's leading source from criminal justice-related data. BJS collects, analyzes, publishes, and disseminates data on crime, criminal offenders, victims, of crime, and the operation of, and expenditures related to, justice systems at all levels of government. These data are used by federal, state, and local policymakers.

Annually, BJS publishes *Bureau of Justice Statistics Key Crime Statistics at a Glance*, a summary of information and data most recently gathered. This report can be found at www.ojp.usdoj.gov/bjs/glance.htm#Crime.

Federal Bureau of Investigation – Uniform Crime Reports (www.fbi.gov/ucr/ucr.htm)

The Federal Bureau of Investigation's (FBI) Uniform Crime Reporting Program (UCR) collects crime statistics from nearly 17,000 law enforcement agencies across the United States, covering approximately 95% of the population. Data are gathered by state and local agencies and submitted to the FBI. Data related to eight categories of crime are gathered: 1) murder and nonnegligent manslaughter; 2) forcible rape; 3) robbery; 4) aggravated assault; 5) burglary; 6) larceny-theft; 7) motor vehicle theft; and 8) arson.

The primary limitation of UCR is that it measures reported crime rather than all crimes committed. Reported levels may vary from community to community as a result of a wide variety of factors, including funding and aggressiveness of local law enforcement agencies. The FBI operates two other reporting systems. The National Crime Victimization Survey collects data on unreported as well as reported crime by surveying a representative sample of households. The National Incident-Based Reporting Systems presents comprehensive, detailed information about crime incidents to law enforcement, researchers, and planners.



Data Sources

Centers for Disease Control and Prevention (CDC) (www.cdc.gov)

The federal Centers for Disease Control and Prevention (CDC) is the lead federal agency charged with protecting the health and safety of Americans, providing information for making health decisions, and promoting and protecting the nation's health through strong partnerships. CDC serves as the national focus for developing and applying disease prevention and control strategies, environmental health approaches, and health promotion and education activities. There are 11 national centers.

National Center for Injury Prevention and Control (NCIPC) (www.cdc.gov/ncipc/)

The National Center for Injury Prevention and Control (NCIPC) works to reduce morbidity, disability, mortality, and costs associated with injuries occurring outside the workplace. One of the federal Centers for Disease Control and Prevention, NCIPC conducts and supports research about causes, risk factors, and preventive measures for injuries outside the workplace, including:

- Unintentional injuries related to falls, fires, drowning, poisoning, motor vehicle crashes (including those involving pedestrians), sports and recreational activities, and playgrounds and day-care settings;
- Intentional injuries related to homicide, suicide, youth violence, intimate partner violence, child maltreatment, and sexual violence; and
- Improving health and quality of life after injuries and preventing secondary conditions among people with disabilities.

NCIPC also funds research by universities and other public and private groups studying the three phases of injury control (prevention, acute care, and rehabilitation) and the two major disciplines of injury control (epidemiology and biomechanics).

HIV/AIDS Surveillance Report (www.cdc.gov/hiv/stats/hasrlink.htm)

The HIV/AIDS Surveillance Report is published annually by the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention, CDC. It contains data about U.S. AIDS and HIV case reports, including data by state, metropolitan statistical area, mode of exposure to HIV, gender, race/ethnicity, age, vital status, and case definition category.

National Center for HIV, STD, and TB Prevention (NCHSTP) – Division of Sexually Transmitted Diseases (www.cdc.gov/nchstp/od/nchstp.html)

CDC's Division of Sexually Transmitted Diseases (STDs) provides national leadership through research, policy development, and support of effective services to prevent STDs (including HIV infection) and their complications, such as enhanced HIV transmission, infertility, adverse outcomes of pregnancy, and reproductive tract cancers. The Division assists health departments, health care providers, and non-governmental organizations and collaborates with other governmental entities through the development, syntheses, translation, and dissemination of timely, science-based information; the development



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of goals and science-based policy; and the development and support of science-based programs that meet the needs of communities.

National Center for HIV, STD, and TB Prevention (NCHSTP) – Division of Tuberculosis Elimination (www.cdc.gov/nchstp/tb/surv/surv.htm)

The NCHSTP Division of Tuberculosis Elimination (DTBE) seeks to provide leadership in preventing, controlling, and eventually eliminating tuberculosis (TB) in the U.S., in collaboration with partners at the community, state, and international levels. To accomplish this mission, the DTBE carries out the following activities:

- Develops and advocates effective and appropriate TB prevention and control policies;
- Supports a nationwide framework for monitoring TB morbidity and mortality;
- Detects and investigates TB outbreaks;
- Conducts clinical, epidemiological, behavioral, and operational research to enhance TB prevention and control efforts;
- Evaluates prevention effectiveness;
- Provides funding and technical assistance to state and local health departments; and
- Provides training, education, and technical information services to state and local health departments.

DTBE publishes an annual TB Surveillance Report. The reports include statistics on tuberculosis case counts and case rates by states and metropolitan statistical areas with tables of selected demographic and clinical characteristics (e.g., race/ethnicity, age group, country of origin, form of disease, drug resistance, etc.)

Behavioral Risk Factor Surveillance System (BRFSS) (<http://www.cdc.gov/brfss>)

CDC's National Center for Chronic Disease Prevention and Health Promotion administers the Behavioral Risk Factor Surveillance System (BRFSS), the world's largest telephone survey. Based on an understanding that personal health behaviors play a major role in premature morbidity and mortality, BRFSS facilitates the collection of behavior-related data on a state-specific basis. State-level surveillance of prevalence of major behavioral risks assists states in planning, initiating, supporting, and evaluating health promotion and disease prevention programs.

National Center for Health Statistics (NCHS) (www.cdc.gov/nchs)

CDC's National Center for Health Statistics (NCHS) provides statistical information to be used by policymakers and health professionals to improve the health of the American people. As the nation's principal health statistics agency, NCHS is responsible for providing accurate, relevant, and timely data. NCHS has two major types of data systems: those based on



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populations, containing data collected through personal interviews or examinations; and those containing data collected from vital and medical records.

National Highway Traffic Safety Administration – Fatality Analysis Reporting System (FARS) (www-fars.nhtsa.dot.gov)

The Fatality Analysis Reporting System (FARS) facilitates the collection and reporting of data for all fatal crashes involving automobiles in the United States, and provides a basis for evaluation of overall highway safety, motor vehicle safety standards, and highway safety initiatives and programs. FARS maintains cooperative agreements with agencies in each state to collect and report fatal crash data in a standard format. Data is available through a web-based “encyclopedia”.



Data Sources

State Sources

Washington State Department of Social and Health Services, Divisions of Alcohol and Substance Abuse - TARGET

TARGET (Treatment Assessment Report Generation Tool) is a reporting management information system used by the Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse. Reporting is required for treatment agencies providing public sector-contracted/funded treatment services and optional for private pay individuals served. TARGET information collection is based on establishing a baseline at admission to treatment and capturing/identifying changes to that baseline upon discharge, thus providing information on progress during treatment.

Office of Financial Management – Population Trends for Washington State (<http://www.ofm.wa.gov>)

The Office of Financial Management (OFM) provides official population counts and estimates. Population figures reported by OFM include all persons who normally reside in the state, including military personnel and dependants, persons in correctional institutions, residents of nursing care facilities, and college students.

Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, and Research and Data Analysis – Washington Needs Assessment Household Survey (<http://psy.utmb.edu>)

The Washington Needs Assessment Household Survey (WANAHS) was a statewide survey of over 7,000 adults designed to measure the prevalence of substance use and need for treatment. The survey was conducted over a 14-month period from September 1993 through October 1994. The WANAHS sample included large number of minorities and other groups in order to facilitate demographic analysis. Several statewide and county-level profiles have been prepared based on WANAHS, the most recent being *Profile of Substance Use and Need for Treatment in Washington State* (1999).

Washington State Department of Health – Center for Health Statistics (<http://www.doh.wa.gov/>)

Data used come from Certificates of Live Birth, Fetal Death, Death, Marriage, and Dissolution. Data for Washington State Vital Statistics are compiled for each year from certificates received before April 15 of the following year.

Washington State Department of Health, Office of Hospital and Patient Data System – Comprehensive Hospital Abstract Reporting System

The Washington State Department of Health's Comprehensive Abstract Reporting System (CHARS) monitors hospital admission trends, causes of hospitalization, and other indices used to evaluate the quality and accessibility of health care in Washington. Key data elements include patients' age, sex, physician, primary and secondary diagnoses, principal and secondary procedures, length of stay, and discharge status.



Data Sources

CHARS does not include data from federal, military and Veteran's Administration hospitals. Also excluded from the system are emergency room visits, data from outpatient facilities, surgery centers, birthing centers, and free-standing mental health, substance abuse, and rehabilitation centers or clinics.

Washington Traffic Safety Commission (<http://www.wa.gov/wtsc/index.htm>)

Collaboration among state, federal, and local partners is key in designing and implementing successful traffic safety programs. Each year the federal government allocates part of the federal Highway Trust Fund to the states to carry out highway safety programs. The Washington Traffic Safety Commission (WTSC) has administered these funds and facilitates these efforts in Washington State since 1967. Governor Gary Locke serves as WTSC chair. WTSC offers several programs, including the following: Impaired Driving, Community DUI & Traffic Safety Programs, Occupant Protection, Police, Traffic Records and Research, Youth, College-Age, Pedestrian/Bicycle, and Public Information and Education.

Washington State Survey of Adolescent Health Behaviors.

The Washington State Survey of Adolescent Health Behaviors (WSSAHB) provides information about the health attitudes and behaviors of Washington youth. A student survey has been conducted in Washington in even-numbered years since 1988, under the auspices of the Office of Superintendent of Public Instruction (OSPI). The WSSAHB includes a sample of public schools students in 6th, 8th, 10th, and 12th grades. The survey provides information on tobacco, alcohol and other drug use, violence, related risk and protective factors, and demographics (age, race, and gender).

Survey samples are selected using a stratified cluster sampling procedure, with schools being the primary sampling unit. Data from student surveys are useful for obtaining statewide estimates of the prevalence of health risk behaviors among youth, examining trends and patterns in risk behaviors, and establishing profiles of persons at risk. Caveats related to the data include:

- Students survey does not represent youth who have dropped out of school. It is thought to be likely that these youth are the most likely to engage in high-risk behavior.
- Health risk behaviors may be underestimated as it is self-reported. Willingness to self-report behavior is subject to social acceptability norms.
- Changes in time of year for survey administration means that students may differ in age and experience from survey to survey, and seasonality factors may affect results. In such instances (as in 2002), data may not be comparable with previous surveys or with national surveys conducted at a different time of year.

